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OCCUPATIONAL THERAPISTS IN THE ARMY MEDICAL SPECIALIST CORPS. Major Maryelle Dodds, Captain Janet Werner, and 2nd Lt. Judith Ouradnik, left to right. Their careers reveal the range of opportunities in the AMSC for selected college graduates. Photographed at Walter Reed General Hospital, Washington, D. C.

Major Maryelle Dodds' career ranges from the 98th General Hospital, Neubrucke, Germany, to the University of Southern California, where she received her master's degree. She has been an instructor at the Army Medical Service School, and a civilian instructor at Ohio State University.

Major Dodds is currently Chief Occupational Therapist at Walter Reed General Hospital. Here, she coordinates all occupational therapy activities, assigning and supervising her staff to provide professional treatment for all age groups, both male and female.

In a varied career as an Army occupational therapist, Janet Werner ranks her present assignment among the most challenging. Currently, she's supervising the O.T. Clinical Affiliation at Walter Reed General Hospital, one of the four hospitals where the program is conducted.

Captain Werner guides newly commissioned officers through an intensive professional program. It includes supervised treatment of patients, ward rounds, field trips, observation of surgical procedures, lectures, conferences, and staff meetings. The program begins in March and August of each year.

After graduating in June 1959 from Mount Mary College in Wisconsin, Judith Ouradnik entered the Army's O.T. Clinical Affiliation Program. She was commissioned a 2nd Lt. for a period of 24 months, and began her affiliation at Brooke General Hospital, San Antonio, Texas, completing it at Fitzsimons General Hospital, Denver, Colorado.

Lt. Ouradnik's 39-week program included the following: clinical application of O.T. in the treatment of physical disabilities, 3 months; neuropsychiatric disorders, 3 months; general medical and surgical conditions, 3 months.

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The American Journal of Occupational Therapy

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Pride of ownership is displayed by some of the youngsters at Children's Hospital of the East Bay, Oakland, California, who made decorations for their entry in the annual Festival of Christmas Trees sponsored by the hospital to benefit its part-pay program. Unique miniature trees and Christmas decorations, sold during the festival's run are donated by branch members and friends of the hospital including doctors, artists and business firms.

Overseer of the seasonal activity which transformed the occupational therapy department of Children's Hospital of the East Bay into a bustling workshop, was Janice Johnson, O.T.R., the hospital's director of occupational therapy. Paper, cotton, paints, glue and string were among the items spread before the delighted youngsters. Imagination did the rest.

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of
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EDUCATIONAL WEAKNESSES AND OCCUPATIONAL STRESS

A SURVEY*

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GEORGE F. ANDEREGG, JR.‡

INTRODUCTION

In the spring of 1957, with the Allenberry workshop conference of the preceding fall in mind,[1] one of the authors* set about interviewing all members of occupational therapy departments in Massachusetts' twelve state hospitals for the adult mentally ill. Over the course of the following year, nearly all of the workers, at the various job levels, were contacted. They totaled ninety-four, and each one interviewed was asked two questions, the open-ended responses to which were recorded for later analysis. (1) "What are the stresses and strains of your job?" and (2) "What would you like to know more about regarding occupational therapy?" Considerable background material of the occupational therapists was collected also, in the hope that some relationship might be discovered between the factors of general education, professional education, length of occupational therapy experience and age and the complaints and inquiries brought forth in the interview.

The aim of this undertaking was to better understand the problem areas so that improvements could be made through the development of special studies and new educational programs. This project seemed a thorough and effective, if somewhat laborious, way for the tensions, discontents and frustrations, and the desires for better tools of knowledge on the part of the state psychiatric occupational therapy staffs to be brought to light. At the same time, there was hope of finding what similarities there might be between the picture of occupational therapy and its future as drawn at the Allenberry conference, and the viewpoint of the average worker toward the profession. If Allenberry's "broad picture of the thinking and activities of a group of leaders in the profession"[2] were to show close kinship to the picture carved out of the average therapist's work, it was felt that this would lend strength and credence to the recommendations of the conference.

The original goal at Allenberry was to suggest the direction which professional education should take in order to develop to the full the potential role of the occupational therapist as a member of the "total treatment team" in psychiatry.[3] The bulk of the conference was in fact devoted to the preliminary but equally important task of defining just what that potential role ought to be; but the end goal of the educational ways and means was not forgotten, and received the full attention of the conference once the task of ideal definition was completed.[4] Before the conference and since, Massachusetts has been much concerned with improving the quality of performance of members of its occupational therapy departments. Over the past few years efforts have been focused on in-service programs for all levels of occupational therapy personnel. In 1955, a two-week institute on psychiatric occupational therapy was offered for the head occupational therapist and one staff member. This was preceded by three preliminary

*Office of Vocational Rehabilitation, Project No. 55, "Rehabilitation of the Mentally Ill." Acknowledgement is made to the principal investigators, Milton Greenblatt, M.D., David Landy, Ph.D., and Bernard Kramer, Ph.D.

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sessions, held monthly, on personality development ego mechanisms. In 1956, a one-week institute, again focused on psychiatric occupational therapy, was given three times so that all members of occupational therapy departments could attend without closing the departments. In 1957, 1958 and 1959, the Commonwealth offered a training program to non-registered members of occupational therapy departments. The first was a four-week, 140-hour training program which included orientation to the other hospital services, psychiatric and occupational therapy theory, and an opportunity for clinical application of activities and therapeutic techniques. This program has now been expanded into a twelve-week, 460-hour course, which has been endorsed by the American Occupational Therapy Association as meeting its requirements for the certification of psychiatric occupational therapy assistants. The response from assistants wanting to take this program has been substantial, a fortunate situation since they, with supervision, must bear a good deal of the work responsibility with today's limited numbers of registered therapists. It was hoped, then, that the pres ent study might give from the practical, grassroots level what the Allenberry workshop gave from the theoretical, top-level point of view: an indication of those areas in which training for psychiatric occupational therapy should be improved both to answer desires for knowledge and, where possible, to eliminate problems and complaints. In addition, it was hoped that various areas might come to light which would call for further investigation through special and more detailed studies.

THE GROUP INTERVIEWED

As previously stated, ninety-four people were interviewed. This number is delineated in Table I.

Title of Position Held	*Number*
Head occupational therapist	8
Occupational therapist	46
Occupational therapist assistant	29
*Recreational therapist	5
*Female attendant (OT)	3
*Industrial therapist	2
*Library assistant	1
Total	94

TABLE I

Those marked with asterisks were included because in the particular structures of their various hospitals they were assigned to the occupational therapy departments as additional members to carry out the department program. This group of ninety-four represented about 85 per cent of the occupational therapy staff in the twelve hospitals. For the purpose of this study, the results as they pertain to these ninety-four (all of whom will be referred to as occupational therapists) are lumped together since the figures justify this arrangement. Any glaring differences are noted.

Of the fifty-four holding the positions of head occupational therapist or occupational therapist, twenty-six (48 per cent) were registered occupational therapists while four more were eligible to take the American Occupational Therapy Association's examination for registration (three of these had let their registration lapse). Table II summarizes the data with respect to the age, educational level and length of experience in occupational therapy.

Age	*Number*	*Percent*
21-30	17	18
31-40	11	12
41-50	29	31
51-65	37	39
Education	*Number*	*Percent*
Less than 12th grade	9	10
12th grade	41	43
1-2 yrs. college	13	14
3-4 yrs. college	25	27
†Graduate work	6	6

†Includes a master's degree in public health, courses in guidance and counselling, education, group dynamics and similar professional courses. Ten people had business or other non-professional training which is not included.

**Experience*	*Number*	*Percent*
Less than 5 years	50	53
5-10 years	24	26
11-20 years	5	5
More than 20 years	15	16

*Includes occupational therapy experience at other institutions, public and private.

TABLE II

The occupational therapy staffs at the twelve hospitals ranged from 6 to 26, with the modal size being nine. Thirty-three of the ninety-four workers were single; fourteen were male. The patient census ranged from 143 to 2,918.[5]

THE INTERVIEW RESULTS

The two questions "What are the stresses and strains of your job?" and "What more would you like to know regarding occupational therapy?" did not, with a few exceptions, bring forth two clear-cut and distinguishable types of answers. As can readily be imagined (and as was an underlying hypothesis of this study) the undirected responses of the occupational therapists often blurred any distinction between the two questions eliciting their answers. It was often hard to tell which question any given comment was answering. A complaint like "I can't understand patient X's behavior; he always does (or refuses to do) such-and-such" is of course also a plea for better knowledge of the psychodynamics of the sick personality. An expressed desire to know more about psychodynamics is also often a complaint that the occupational

therapist was not being included to the fullest extent in the therapeutic planning for the patients with whom he worked; that he was not a full-fledged member of the "total treatment team."

After a preliminary reading of the interviews, it seemed that nearly all of the comments recorded which were at all relevant to our purposes fell into less than two dozen relatively specific categories. After further analysis, it became apparent that the most frequent comments could be dealt with quite adequately under the fourteen headings presented here. Table III presents the fourteen catgories individually, with a skeletal definition, ranked by frequency of occurrence.

Rank	*Frequency*	*Category*
1	70	"There is too little communication between occupational therapists and the other staff members, and too little integration of occupational therapy into the 'total treatment team'."
2	51	"Better buildings, better-arranged clinics and working areas, and better equipment would make for better occupational therapy."
3	46	"Other staff members (not including psychiatrists) misunderstand and underestimate the proper functions and the true potential of occupational therapy. They do not cooperate with us, and we have many conflicts with them."
4	34	"Being an occupational therapist is very frustarting. One feels rejected by the rest of the staff and inadequate. It is hard to evaluate one's work when there is little communication or recognition."
5	32	"Psychiatrists too misunderstand and underestimate the proper role of the occupational therapist. They treat him/her as the 'poor relation' of the treatment team."
6a	30	"The referral and dismissal procedures to and from occupational therapy and the opportunities for patient follow-up, when they exist at all, are inadequate."
6b	30	"How do you motivate patients to cooperate and participate in occupational therapy activities. How do you control them?"
7a	29	"How do you use occupational therapy as a psychotherapeutic device as opposed to a diversion for keeping the patients busy?"
7b	29	"It would be helpful to know more about certain therapeutic devices."
7c	29	"We are understaffed and overworked."
8	24	"Occupational therapy lacks organization."
9	23	"It would be helpful to be able to understand the meaning of patients' behavior."
10	11	"It is difficult to know just what the proper role of occupational therapy should be in the therapeutic community."
11	8	"The transition between being a student and becoming an occupational therapist should be made easier and more instructive."

TABLE III

Of these categories recording what are largely "stress-and-strain" answers, nearly all fall into a larger category of what might well be called professional self-denial. These are expressions of non-acceptance and exclusion and result from what occupational therapists feel is their lack of full and equal professional status (at least in these hospitals) as members of the total treatment team. This phrase has already appeared more than once in this paper, and at the Allenberry workshop it appeared time and again, coupled with the then-to-be-defined goal of occupational therapy's status as a true therapeutic profession. Strong professional education must be an accompaniment of these achievements. The headings (Nos. 1,3,4,5 and 6a) comprising the professional self-denial category will be discussed together. A second group (Nos. 6b,7a,7b and 9) of rather clearly related categories contains most of the "know more about" responses. The desire is expressed to acquire further knowledge and to do better. In general these deal with the various aspects of occupational therapy as a psychotherapeutic device. In between these two main groups, however, there is a middle ground of several categories (Nos. 8,10 and 11) which are related to both; the uncertainty over occupational therapy's present role is expressed and coupled with pleas for knowledge as to what it should be. A fourth grouping (Nos. 2 and 7c) comprises the problems of inadequate staff and equipment for tasks. Doubtless this arises largely from the lack of endless funds in our state hospitals. As discussed in these major groupings, the categories are not always presented in order of frequency.

1. *PROFESSIONAL SELF-DENIAL*

(1) *There is too little communication between occupational therapists and the other staff members, and too little integration of occupational therapy into the total treatment team.*

This statement easily ranked first in frequency of appearance; it was recorded (with minor variations) 70 times, not counting elaborations and reiterations in any one interview. No hospital escaped this, nor was any staff level silent about it. There was little difference in its relative frequency of occurrence between registered occupational therapists and occupational therapy assistants or between those who had five years of experience and those who had twenty. A typical statement of this sort might be: "There isn't enough communication between the occupational therapists and the rest of the staff. We seldom (or never) have staff meetings, and when there are regular meetings the occupational therapists aren't included. It seems to me the doctors ought to include us when

they discuss the patients. It would certainly help us in knowing how to deal with them." One registered occupational therapist reported that there were weekly meetings in his hospital, attended by the psychiatrist, the nurses, and the attendants, which the occupational therapists and social workers were not allowed to attend, though both groups had asked to be included. When the head of the staff was asked why the attendants were included when occupational therapists and social workers were not, he replied that the attendants needed some recognition to support their morale. An occupational therapy assistant said that in his two years at his hospital not only had he never attended a staff meeting, he had never met the head of the staff.

Several of the categories following can easily be seen to be closely related to this one, either as partial causes or effects or as more specific aspects of it. Certainly the feelings described were most pervasive throughout the interviews. Professional pride was at stake. Feelings were hurt because of not being included in meetings being held. However, another aspect was concerned with the lack of any interdisciplinary meetings and the disappointment ensuing from the expectation of being able to participate actively in such meetings, which is an ideal that occupational therapists are taught exists.

(2) *Other staff members (not including psychiatrists) misunderstand and underestimate the proper function and the true potential of occupational therapy. They do not cooperate with us, and we have many conflicts with them.*

This complaint appeared in its various wordings 46 times. A few hospitals received only one or two such comments but one was especially productive of the remark. This institution has an occupational therapy staff composed largely of young, single, well-educated occupational therapists, most of whom have fairly short job experience. Presumably their recent professional training, with its emphasis on the proper high status of occupational therapy, coupled with the fact that this is a hospital where there is a good deal of emphasis on research and a total treatment approach, explains their strong reaction to the problem.

It seems probable that some of the total reaction to this situation must be written off as inevitable rivalry between the various services. But a great deal of it is apparently well founded. The following remarks are typical:

"Nursing thinks occupational therapists do nothing. This attitude bothers new department members. We need better support from nurses for occupational therapy." "Some of the ward personnel forget what occupational therapy is for. This is especially true of the continued-service personnel, those who have worked here for a long time. We work with a patient for a while, until it is time for her to go back to the ward. The attendant there gets tired of being pestered, so he sends her back to us." "Staff visitors say to us: 'You have a big workshop; why don't the patients make big things?'" "A nurse said to me: 'Cutting out paper-dolls! I'd love to have your job!'" "If all the patients aren't busy all the time, personnel say, 'Why isn't Mrs. X doing something?'" "Ward personnel send us patients and say 'She's good. You can take her. She can make pretty things.'" "Ward personnel don't cooperate with us in sending down the patients. We have to stop and go get them, and then take them back. The nurses tell us we should be the ones to lift patients from bed to chair to wheelchair. We haven't been trained to do that." "I worked for three months training an attendant to help with occupational therapy. Then one day she was removed to another building. Now I can't get anyone else who is interested."

(3) *Psychiatrists misunderstand and underestimate the proper role of the occupational therapist. They treat him as the "poor relation" of the treatment team.*

This item appeared 32 times. Psychiatrists seem to play no favorites among occupational therapists for these complaints were evenly spread throughout the hospitals (save for one where no such remark was registered) and across the various subgroups of the total ninety-four. It seems from the comments that this problem is a mixture of "don't know" and "don't care." The occupational therapy assistant who in two years has yet to meet the head of the staff provides one example. Perhaps if this were merely a matter of hurt feelings over social niceties it would not be worth any comment. But other complaints make it clear that more is involved. Exclusion from staff meetings as already mentioned is a more important illustration, as are the following:

"Doctors make out referral cards but they have no idea how occupational therapy can help patients. They seem more interested in drugs, EST and group therapy than in the ancillary disciplines." "We asked if we could have staff meetings, but he said it took too much time." "The doctors think we are here to keep the patients busy."

(4) *Being an occupational therapist is frustrating. One feels rejected by the rest of the staff and inadequate. It is hard to evaluate one's work when there is little communication or recognition.*

This type of complaint was recorded in 34 interviews. It is a problem to which younger people (under forty) and older people with long occupational therapy experience (ten years or more) seemed remarkably immune. Those over forty who have shorter work experience (under ten years) mostly occupational therapy assistants, registered the great bulk of these complaints. In light of the other complaints in the self-denial category, it is no surprise that many should have this kind of personal reaction to the frustrations of their job. No doubt, however, some of these comments would have appeared even had the general status of the occupational therapist been more comfortable. Needless to say, among the recommendations of the Allenberry conference were changes in occupational therapy education designed specifically to promote both good mental health and self-confidence in the occupational therapist,[6] as well as those general changes pointing toward higher professional qualifications and hence higher status and recognition. It is hoped also that the in-service program now being used for occupational therapy assistants in Massachusetts will be of some assistance in helping this particularly vulnerable group maintain its confidence and professional identification.

(5) *The referral and dismissal procedures of patients to and from occupational therapy, and the opportunities for patient follow-up, when they exist at all, are inadequate.*

Thirty interviews contained references to this problem. It appeared to be one of the major sources of frustration to occupational therapists in all the sub-groups. The doctors' indiscriminate signing of referral cards has already been mentioned, as have the criteria by which other personnel are prone to judge occupational therapy candidates ("She can make pretty things"). One might also gather from the paucity of meetings which include occupational therapists just how probable it is that there exists much coordination of occupational therapy with the other therapeutic approaches. "Sometimes doctors and staff will send no new patients at all to occupational therapy, and the occupational therapist will have to go out and recruit. Then someone will send four or five new patients at once and since the occupational therapist won't be able to get started with all of them at once, some of them get discouraged and leave, and they don't want to come back." It appears that quite often patients are sent to the occupational therapist when he has absolutely no knowledge about them or their disorder. He is left on his own to take what time he can spare to get to know the patient. Seldom if ever does he get any advice from a doctor as to what form of activity might be best (or harmful) for the patient, nor does he get any information as to whether or not the patient is suicidal, prone to escape, or the like. This should not be surprising in light of the way in which occupational therapy is often viewed by doctors and staff. The following typify complaints about follow-up and dismissal:

"If a patient is not on the ward, it is assumed that he is in the occupational therapy clinic, but he may not be there. Often an occupational therapist cannot find a patient and has no way of checking on his whereabouts." "Patients are sent to occupational therapy to get them off the wards. But no one ever asks occupational therapists for information about the patients." "I would like to pass on information about the patient to the doctor. But I don't know what he wants to know." "My opinion about the patient is never considered." "Doctors don't seem to remember where patients are referred." "Patients are assigned to occupational therapy, and later assigned to industry without notifying occupational therapy."

II. *THE MIDDLE-GROUND.*

(6) *It is difficult to know what the proper role of occupational therapy should be in the therapeutic community.*

While the statement was made explicitly enough to be recorded as such only eleven times (putting it next to the bottom in the list of fourteen), the feeling which it expresses is much more pervasive by implication throughout the interviews than is indicated by its low position on the list. Obviously when one feels treated as the poor relation, when one's opinions and therapeutic abilities seem rated next to zero, and when one's professional self-esteem is accordingly low, it is not surprising that one begins to question the potentialities as well as the limitations of one's calling. What is the proper scope of occupational therapy? What is expected? What is the role and function of occupational therapy from the hospital's point of view? When occupational therapy is treated as a catch-all, how can one draw the line against performing non-occupational therapy duties? Is ocupational therapy after all a form of busy-work for keeping a lot of patients out of mischief? Is it properly a form of psychotherapy which ought to be individually prescribed to affect the course of an illness and improve a patient's condition? What is the role of the occupational therapist in the establishment of a therapeutic milieu on the ward?

Most assuredly many more than eleven occupational therapists had questions of this sort in mind, whether explicit or not. The work of the Allen-

berry conference, with its delineations of the province and goals of occupational therapy, would answer many of these questions at the theoretical and ideal level. One trusts that when the educational recommendations of the conference can be put into effect so as to strengthen the occupational therapists "distinctly professional status" both in the hospitals' opinion and in the mind of the occupational therapist himself, these questions will be answered for him on the practical level as well.

(7) *Occupational therapy lacks organization.*

The 24 comments using the words above certainly are not surprising in light of the foregoing. But they reflect also confusion within the occupational therapist's mind as to how to handle specific tasks of using activities, as well as being jack-of-all-trades and errand-boy. As such this not-too-illuminating comment lies in the middle-ground between complaining and wanting to know. Its cures are those of the other troubles here expressed.

(8) *The transition between being a student and becoming an occupational therapist should be made easier and more instructive.*

This matter drew only eight specific comments, yet it must be felt that its importance is much greater than its bottom rank indicates. Allenberry's educational recommendations recognized this:

> A definite need for *closer correlation between the academic field and clinical practice is indicated* . . . The most difficult period for the occupational therapy student is the transitional period from academic to clinical setting. Preparation and guidance toward this period must be skillfully handled . . . Improvement in this area can be achieved by *planned opportunities for experiences in academic and clinical fields which are designed to promote emotional maturity, objectivity and self-understanding.*[7]

III. *WE WANT TO KNOW.*

(9) *How do you motivate patients to cooperate and participate in occupational therapy activities? How do you control them?*

Of all the specific desires for knowledge, this one was mentioned most often, in 30 interviews.

"A patient has the ward personnel afraid of her. She wants to leave the hospital, and threatens to tear up the place if she can't or if people do not give her cigarettes or fulfill other requests. What can I do?" "Continued-care patients don't want to try anything new, they are in a rut. How can a new worker get them to change?" "Patients who were ordered to attend occupational therapy by the doctor on admission refuse to attend an occupational therapy clinic in another area when transferred. They say they have had enough of it; must be wooed back." "How should the 17-to-22-year-olds be approached? Should they be babied or expected to attend occupational therapy? It's hard to get them moving as they just want to play cards. Is it ever possible to motivate the real old who just sit?" "Patient talks, talks, talks, talks all the time. Some patients will berate the talker for this, others ignore it. How can the occupational therapist help the group to speak out more in the effort to modify this behavior? How far should one let the patient go?"

(10) *How do you use occupational therapy as a psychotherapeutic device, as opposed to a diversion for keeping the patients busy?*

This and the next type of inquiry both appeared in 29 interviews, often with the same occupational therapist. Both seemed of special interest to workers over 40 and with limited (less than 5-years) experience. Twenty-one of those interviewed were occupational therapy assistants. It will be seen that many of the questions refer *to the therapeutic use of self* as well as of activities. This emphasis was omnipresent at Allenberry, and perhaps more than any other single core concept marks the distinct shift towards making the occupational therapist a true member of the therapeutic team.

"What is the meaning of the activity to the patient? Are the patients receiving the right activity? What crafts and activities are suitable for patients of different psychoses? How do you know what to give to whom?" "Should patients have a choice of activities or should the therapist decide for them?" "How can the occupational therapy area be set up to help the patients? Is it too noisy for a manic? How much noise should groups be expected to tolerate?" "What is the effect on the patient of basement shops, especially those that are hard to clean and have dirt on pipes and bricks?" "How can patients who need control be given it in occupational therapy? Is one being too liberal? Are the limits practical? Patients wander out of occupational therapy clinic to another discipline's office. Is this too permissive? When should patient be sent back to the ward? Is he being too active? How can patients help you control and should they?" "I politely eliminated an aggressive patient from the group rather than let her disturb the members. Is this the best way to handle the situation?" "Patients get provoked at you. What does it mean? How should it be handled?" "How long should one talk to a patient who asks for an opportunity to talk with you but whose talk is 'full of delusions'? As long as one-half-hour or three-quarters

of an hour?" "When should mistakes in patients' work be corrected? When should they be left?"

(11) *It would be helpful to know more about certain therapeutic devices.*

Of the 29 comments, 14 were in reference to groups. This therapeutic tool received a great deal of attention at Allenberry. The entirety of Chapter 3 of *Psychiatric Occupational Therapy* is devoted to it, and it receives further attention under the discussion of education.[8] Typical comments: "How do you make a group feel like a group? How do you turn an aggregate into a group? How should groups be selected? Should groups have common goals, perhaps to be achieved by a careful selection of members?" "How should patients be controlled in a group? Let the group do it? How?" "How many in a group can you treat as individuals?"

Six were in reference to occupational therapy activities or crafts. "I wish I knew more activities. Patients get bored or they won't get interested, and I feel I'm running dry."

Five were in reference to drugs. "How far can you push a patient on drugs? Should you?"

One each was in reference to the use of art, sheltered workshops, physical therapy, and research.

(12) *It would be helpful to be able to understand the meaning of patients' behavior.*

Twenty-three interviews contained inquiries about the significance of various forms of psychotic behavior. More than half of this number had less than five years experience, all but three had less than ten. It was not clear whether the lack of such inquiries from those with long experience was the result of improved knowledge through that experience or of resignation and loss of interest after years of frustration. Of this number one-third were registered occupational therapists. "A lady was butting everyone with her head. She fears fire and lighted cigarettes. She thinks her hair is afire and birds fly out of her head." "Working on a red apron upset one patient. Why? How should I have handled her? Would knowing her background have helped?" "One patient was weaving, beat the material too much and got very excited. Was that bad? How can you tell?"

The enriched educational background coupled with carefully planned clinical practice as recommended by the workshop would undoubtedly be of great help to occupational therapists in supplying many of the answers to the above questions. Also, presumably the greater cooperation of psychiatrists which hopefully would result from occupational therapy's gaining a stronger professional status would be of assistance to the occupational therapist in dealing with these problems.

IV. *INADEQUATE STAFF AND EQUIPMENT.*

(13) *Better buildings, better arranged clinics and working areas, and better equipment would make for better occupational therapy.*

There were 51 comments in this category which was second in terms of frequency. The items ran from mild inquiries about the best way of arranging a working area to irate protests about staff members who don't clean up after themselves and about others who borrow occupational therapy tools and don't return them. More serious still were complaints about competing noise from TV sets distracting patients involved in occupational therapy; building layouts which make the trip from ward to clinic most difficult and make keeping track of patients next to impossible; the lack of sufficient telephone service between areas; and the like. Further protests were heard that the occupational therapist thinks he must often spend his own money to buy materials for occupational therapy use which if ordered through regular channels might never arrive, or certainly not for weeks. One occupational therapy assistant bought, among other things, a sewing machine and a typewriter for patients' use.

(14) *We are understaffed and overworked.*

These words or their synonyms were heard 29 times. Complaints ranged from annoyances like having a "chair round-up" at the end of each day to get back the numerous chairs borrowed but not returned by other personnel, to deep concerns about Sunday and evening assignments which break the continuity of clinics and prevent patients from regular attendance, and about having to work with such large numbers of patients that any personal contact or therapeutic effect is purely accidental. It may be supposed that the understaffing could to some extent be alleviated if a higher professional status of occupational therapy attracted more people to it; but higher status must of course be accompanied by suitable pay and by enough occupational therapists.

DISCUSSIONS

When viewed solely in the context of this article the complaints and inquiries set forth in the interviews seem a most discouraging indication of how difficult it is to be an occupational therapist. If this inference is too broad, the interviews seem at least quite a strong indictment of occupational therapy in the Massachusetts mental hospital system. To the authors, who are rather proud of the quality of Massachusetts hospitals, such an indictment would seem too harsh. It is certainly true that there exist several serious problems, some wide in scope so as to encompass all the hospitals

interviewed, some less sweeping, and confined to certain hospitals or certain groups of workers. Any value which this study has lies in the accuracy with which the interviews point up these real problems.

On the other hand, one must bear in mind the questions which elicited the responses set forth above. Put specifically, when you ask someone to tell you what he wants to know more about in reference to anything, he is bound to present quite a list unless he is not interested in the subject. And when you ask someone, anyone, to tell of the complaints he has about his job, the chances of a strong response are excellent. We are looking only for the trouble spots.

NO COMPARATIVE DATA

All of which is to say that to take the results of these interviews as an absolute measure of the contentment and competence of the occupational therapist involved would be most unwise. We have no comparative data, no controls, no interviews of social workers or nurses from the same hospitals, or of occupational therapists in similar or dissimilar hospitals in Massachusetts or elsewhere. Attributing the difficulty only to the occupational therapist may be a misinterpretation of the data which comes about from lack of discussion with other disciplines to see whether they are not suffering from the same feeling. Yet we do feel that these data have a certain validity as far as delineating the true problem areas and weak spots in occupational therapy education. This statement is made on the basis of the unmistakably frequent recurrence of the views represented in these fourteen categories. Even those appearing least often were obviously closely related to those appearing more frequently, and they were present by strong implication in many other interviews. Further confidence in our results comes from comparing them with the personal impressions and observations of people closely connected with the field at supervisory levels; and of course, it is both interesting and encouraging to see how much overlap there is between the findings here and the work at Allenberry.

Granted then that the problems and desires of the occupational therapists are rather well indicated by the present project, it is interesting to speculate as to the etiology of the material discovered. Most interesting of all, perhaps, and not of least significance, is why the professional self-denial and why the confusion over occupational therapy's proper role? As to the latter, this is not the place for an extended discussion of the origin and development of occupational therapy. But it is clear that over the past decade, psychiatric occupational therapy (not unlike the larger role metamorphosis of psychiatry in general) has stood at a turning point where its need and desire for a higher and more distinct professional status has been accompanied by a need for a professional rationale and definition of scope and goals. In fairly concrete and detailed terms, the Allenberry workshop in 1956 provided a good orientation and a jumping-off place. The recommendations have been made (and well made, if the results of our data are any indication). Now occupational therapy has to act on these ideas, and its professional advancement hangs in the balance. As previously explained, Massachusetts has made some revisions in the programs available to its workers. Workshops on recreation, supervision and industrial placement have been held within the past year and more are being considered. Perhaps further studies arising out of this one will show the way to still more effective improvements in both post-graduate and in-service education. In addition, a 1960 survey reveals that the number of different meetings within the hospital which the head occupational therapists attend ranges from 1 to 12; the occupational therapy staffs attend from 1 to 7. The average for the former is 7.66 and for the latter 3.66. This includes such meetings as those of the entire occupational therapy department, department heads, medical staff, area teams, rehabilitation personnel, etcetera. The frequency of the meetings vary from once a week, to once a month or to twice a year.

CONCERN WITH STATUS

The professional self-denial was viewed by one author as the occupational therapy rejection syndrome. To him, professional self-denial connotes some kind of masochism as the refusal of occupational therapists to take a cup of coffee with the rest of the staff.

Both the professional self-denial and the concern over occupational therapy's proper role may be viewed from the results of studies of the hospital as a social system. Discontent among ancillary professional personnel (psychologists, nurses, social workers and occupational therapists) was discussed in a paper by Lefton et al.[9] It was pointed out that those who embrace the "therapeutic community" school of psychiatric thought have relied on interpersonal-dynamic concepts with the result that there has been strong emphasis on the need to recognize that all who come in contact with patients have a therapeutic potentiality. This emphasis has resulted in a blending or virtual elimination of any distinction in function of the various groups. Skill in interpersonal relations is being used as a yardstick rather than the differing functions for which the various team members are trained. This was thought to be a possible explanation for current dissatisfac-

tions especially when viewed in the hierarchical setting of authority and prestige in which the personnel operate.[10]

The thesis that concern with status and prestige has become an extremely important determinant of work satisfaction of a particular group of psychiatric social workers was examined in a study which included a comparison with a group of 40 nurses and was undertaken by the research division of the Columbus Psychiatric Institute and Hospital. Findings tend to support this thesis.[11] The satisfaction of the social workers was related to the amount of status accorded them at work while the satisfaction of the nurses was related to the amount of security they thought they had. Social workers felt more deprived than the nurses in relation to the amount of prestige they expected from the public and other professional persons. This feeling was found to be justified on the basis of interviews held with the public and professional personnel. A further sense of deprivation was related to pay. Social workers feel theirs is lower than it should be, even though it is higher than the income of nurses. The nurses indicated that their pay was adequate.

A second complementary study was concerned with the status and decision-making attitudes of 53 mental health specialists (including occupational therapists) in one psychiatric hospital.[12] There was high consensus among the staff that status and prestige were accorded in the following order: senior psychiatrists (ward administrators), residents, clinical psychologists, social workers, nurses and occupational therapists. Except for the nurses being placed after the residents, this was also seen as the order in terms of decision-making influence. The staff also agreed on the size of the gap between the psychiatrists and the ancillary personnel. Furthermore, those at the top wished to maintain this distance while those below wished to shorten the gap (or would like more status than they perceive that they have). This spread and the reaction to it was also true in relation to decision-making influence.

A further interesting finding showed that on wards where psychotherapeutic techniques were the major form of treatment, the ancillary personnel tended to emphasize greatly their desires for greater status and decision-making influence while this was minimized on wards where organic methods of treatment were utilized to a greater degree.[13]

Other factors which might be examined for their relationship to the role and feelings of nonacceptance of the occupational therapist are (1) the image which others have of the occupational therapist, i.e. the conceptions and expectations that members of one group hold of the skills, tasks and attitudes of other groups do not seem to be congruent nor accurate;[14] (2) the effect of a predominantly female professional membership in the hospital hierarchy; (3) the relationships between and within the hospital's many occupational groups and the levels of training as related to orientation; and (4) simultaneous but not necessarily compatible goals and mobility.[16]

CONCLUSION

This study should serve as some indication of the extent to which the Allenberry conference had its finger on the pulsebeat of its profession. An over-all view of this rank-and-file commentary shows in how many places the conference made specific suggestions designed to correct difficulties which the ordinary occupational therapist appears to have, and how often its suggestions for educational revision and its delineation of occupational therapy's proper status can serve as potential answers to questions like those put forth here. The professional self-denial should be alleviated by the recognition that must come in time once occupational therapy's potential professional status is more fully achieved. And of course anyone reading the workshop's view of these goals would have a good start toward answering the question of occupational therapy's proper role on the therapeutic team. The workshop's specific discussion of the transition from student to clinician, of the fuller use of both activities and self as truly therapeutic tools, and its thorough discussion of groups are mong the most striking points at which Allenberry's theoretical accomplishments can be seen to have real bearing on the practical problems of day-to-day occupational therapy work. And as for our own program in Massachusetts, it is our hope that, for now, the newly expanded in-service training program for occupational therapy assistants will be a good answer to the problem of the occupational therapy assistants' vulnerable self-confidence which, at least in the twelve hospitals studied, seems indeed to exist; and that it will help prepare the occupational therapy assistant to carry the heavy burden which is today thrust upon him. For the future, perhaps further exploration and more detailed studies will aid in pointing out the proper direction for still more effective educational developments, all towards the goals which Allenberry delineated.

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(*Continued on Page* 270)

WORKING WITH PSYCHIATRIC ATTENDANTS IN LARGE HOSPITALS*

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INTRODUCTION

One important function of an occupational therapist in psychiatric hospitals is to extend himself through attendants.[15] This job is of particular significance in oversized and understaffed institutions which find it hard to provide even custodial care for their patients. Attendants who assume the main responsibility for patient care have difficulty creating ward conditions which offer patients a meaningful living experience. The attendants often receive little support from the professional personnel who establish orbits of operation so that they rarely take a turn through the unlovely and frustrating wards. Notman[11] expresses it this way: "The establishment of special facilities by various ancillary therapies keeps the ward the same, barren isolated 'cold storage unit' in which patients will be placed between their trips to various therapeutic activities." Undoubtedly a schizophrenic's personal fragmentation is not counteracted by the fragmentation of the large hospital where he is perceived and treated differently by various departments. Ward living should be the first, rather than the last place, to be concerned with patient treatment. Since attendants are generally in charge of the wards, trained personnel, including occupational therapists should not reach out to patients *past* attendants, but work *through* them. In other words, a sociotherapeutic approach rather than a psychotherapeutic approach is in order.[14]

DIFFICULTIES IN WORKING ON WARDS WITH ATTENDANTS

My experience on a research project, designed to train attendants, in other hospitals, my conversations with other occupational therapists and studies in the literature lead me to believe that the problems discussed in this paper are common in many hospitals. Obviously all hospitals do not function alike nor do all attendants. Readers can undoubtedly cite many exceptions to the generalizations made here. These remarks may not be appropriate for all wards in large hospitals; however, they may be helpful in situations where occupational therapists and attendants alike experience some frustration and dissatisfaction in upgrading ward milieu.

Occupational therapists in large hospitals often find ward programs difficult to establish. The number of wards make it difficult to set up programs with day-to-day continuity. Yet the therapists are often subject to vague and frustrating pressures from doctors to "reach more patients." Although the therapists may make some attempts to meet these demands, they often harbor feelings that they are performing a job of secondary importance. Programs in large wards seldom involve intensive patient treatment; they are considered merely "diversional" by the therapist and "something to do" by other personnel.

Intensive patient treatment, usually carried out in an occupational therapy clinic, is often infinitely more appealing than trying to change milieu on wards immobilized by inertia and the status quo. Intensive patient treatment is more interesting and more in keeping with professional training than is a "diversional" program. Also, a therapist has more control in the occupational therapy clinic, as this little world is manageable.

If the occupational therapist ventures onto the wards, he often does so as an outsider. This is necessarily so if his contacts are limited. Some have noted that occupational therapists who function mainly on the ward develop loyalties to it rather than to the department; those who function sporadically on the ward do not become an integral part of it and are considered outsiders by ward personnel. Outsiders in any situation are more likely to be regarded as disrupters of the status quo than to be received with open arms.

An ocupational therapist has a professional self-image and concept of his role which is generally not shared by attendants: he is a trained professional person with some knowledge of psychiatry and a contribution to make in patient treatment; his efforts and ideas deserve some consideration. Attendants may not, however, act in accordance with these views. The therapist may well be regarded as an interloper, an interfering foreigner, or one of those people who wants to be nice to patients but who really doesn't understand the need for discipline because he isn't around "when the lid blows off." The therapist

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is likely to return the compliment and pigeonhole the attendant in the "non-therapeutic" category. It is easy to interpret this type of difficulty as a problem between two individuals when in actuality factors in a broader context can clarify the situation.

THE HOSPITAL AS A SOCIAL SYSTEM

Recently sociologists and anthropologists have made contributions to psychiatry by studying mental institutions as social systems. As members of that system we should acquaint ourselves with their comments. Five relevant examples concerning the hospital as a social system are given.

(1) Stanton and Schwartz's[12] observations concerning the relationship between staff conflict and severe patient disturbances highlight the importance of staff unity. In their study of a ward of acutely ill females they found for every sustained patient disurbance there existed a corresponding covert disagreement between two staff members concerning that patient. The upset subsided when the staff members communicated directly with each other on their differences. Without further investigation it cannot be stated axiomatically that all patient upsets are related to covert staff conflict. Yet we might think twice before we attempt to work with a patient in what we think is the "right" way in opposition to other personnel, including attendants.

(2) Cumming and Cumming[8] report a study attempting to better attendants' functioning by utilizing the attendants' evaluation of their own group In upgrading their hospital they decided to create new positions, those of nursing officers, to act as change-agents for the wards. Instead of appointing the attendants they felt would make the best nursing officers, they chose the ones who were looked upon as leaders by their co-workers.

(3) Grold's[9] account of attempts at ward change portrays the disastrous results of ignoring part of the social system. The physician worked with nurses and patients to improve conditions, thus by-passing the attendants who naturally scuttled the program. When the attendants' active support and participation was solicited, the program met with some success.

(4) Henry[7] describes the worker's frustration produced by the multiple subordination system prevalent in psychiatric hospitals. He states that the characteristics of an institution are determined by its organizational structure. He describes four types of organization, two of which are characterized by simple subordination in which a single worker is responsible to a single person. In the two multiple subordination systems, a single worker is responsible to several people. Although industry has eliminated much inefficiency and emotional stress by converting to a single subordination system, mental hospitals have not. We all know that an occupational therapist may be subject to his department head in one respect and to one or more physicians in another, while people not officially responsible for him but above him in the administrative hierarchy may make demands on him. Also, he must deal with maintenance and supply personnel who are not above him administratively but, who are in a position of power as far as he is concerned. In like fashion the attendant has demands and controls set upon him by many people other than his nursing supervisor. Physicians give him orders, social workers and psychologists expect cooperation, occupational therapists want assistance and control certain supplies, the maintenance people can give or withhold service, visitors expect certain demands to be fulfilled. Henry concludes that certain undesirable characteristics of mental hospitals are related to this multiple subordination system. They include "detachment of department heads from workers, workers from patients, and the masking of conflict under routine or frozen professional competence."

(5) Our recent research experience provides an example of confusion generated by tampering with an existing social system. Our research ward was set up with chronic patients and attendants all transferred from various parts of the hospital. Not only did the attendants have to weather the transfer, but they were unused to having five professional people full-time on the ward. The confusion in roles became so great that attendants initially failed to perform the nursing tasks that were taken for granted on other wards. It seemed that by tampering with part of the system, we created many problems.

GENERAL CHARACTERISTICS OF ATTENDANTS

Some general characteristics of attendants should shape an occupational therapist's expectations of and contributions to them. Of course there is wide variation from the generalizations given here; however it is believed they can be applied to a goodly proportion of the attendant population. Attendants' isolation, their reaction to patients, to each other and to professional staff, and their concepts of the function of patient activities are of interest.

Isolation. Attendants are isolated more than any other group of workers in the hospital. They generally bear the greatest burden of patient care and receive the least support from professional personnel. They are expected to keep the ward clean, to transport patients here and there, to keep the medications straight. When community anxiety over escaped patients mounts, it is trans-

ferred by the hospital administration to attendants. Few professional people seem to be concerned with attendants' fear of being hurt physically by an aggressive patient or hurt emotionally by a verbally abusive one. One of the most malignant results of attendants' isolation is their lack of opportunity to identify with professional personnel. In fact, their opportunity for identification goes in the wrong direction, i.e., toward patients with whom they have prolonged contact. They easily identify with patients who function on a relatively high level and can't understand why they can't "really shape up." When the more sick aspects of a patient's personality manifest themselves, the attendants "just can't understand it" and they become threatened because one who acts so much like themselves can also act so sick. On the other hand, they blossom out with new strength and resources when they do identify with mature figures. This observation has important implications and we will return to it later.

Reaction. Attendants' reactions to patients can give occupational therapists a clue as to our expectations of them. Too often I think we operate on the basis of our preconceived notions of how we think they should react. It is not surprising that attendants react to patients much in the same way they react to other people. They do say that patients are "sick," yet they'll complain about their laziness and lack of cooperation, and react warmly to a patient's compliment. The utter devastation of psychosis generally escapes them: the hopeless confusion, the all-pervading sense of guilt, the fluid self concept, the perceptual difficulties, the magical and illogical ways of thinking, the intense rage or terrifying fears. Attendants should not be expected to grasp these difficult concepts, although they don't have to be withheld from those that are interested.

It is mostly on an intuitive feeling basis that attendants react to patients. If a patient in whom they have invested heavily acts out or regresses they feel double-crossed, "How can he act that way after all I've done for him?" They often freely "give" to patients but they expect a corresponding return in patient gratitude and/or improvement. Or if a patient becomes too demanding they withdraw. It is at these times attendants need support and encouragement from supervisory personnel to prevent the attendant's own withdrawal or "acting-out" toward the patient. When the patient-attendant relationship poses no problems, it often results in considerable patient improvement; indeed it is one of the tools of treatment possessed by large hospitals.

Involvement. Sometimes attendants keep their distance from patients by treating them impersonally en masse and "only doing for one what can be done for all." On the pretext of fairness, they keep themselves from becoming involved with any one individual patient. On our project interestingly enough, attendants criticized fellow personnel for lack of fairness only when they felt the patient was being "spoiled." When no one objected to the type of attention given to the patient, the special attendant-patient relationship was satisfying and beneficial to both.

Fear. The underlying fear of violence in the attendant population runs deep. On our project, tales of the feats of disturbed patients were part of the attendant folklore and many a discussion touched off a whole series of additional tales. One attendant suffered an acute anxiety attack upon hearing of her impending transfer to a building in which it had been extremely hazardous to work ten years previously. When another attendant described an incident with a violent patient, an attempt was made by the research staff with helpful intentions to interpret the patient's behavior; her reaction was a hurt, "You don't care if I get killed." Often patient disturbances were considered to come and go without particular rhyme or reason, "She gets like that every once in a while. You just have to put her in seclusion and in a few days she'll be all right again." Combating the unknown and unpredictable is one of the worst frustrations people can experience.

It is not surprising that hand in hand with fear of aggression goes concern with control. If one is in control one need not fear aggression. We noted a curious phenomenon which I call the all-or-none law: Either one has complete control or one has none; there is no middle ground. Complete control over a disturbed patient was equated with complete physical control, i.e., seclusion or incapacitating medicine. Attendants were often loath to try measures that were "sometimes" effective before resorting to the more drastic ones. The all-or-none law was extended to other areas besides violence. "If we open the doors, we can't keep track of patients *at all.* How can we when they can come and go completely as they please?" Measures which provided some control such as explanation and discussion of limits with patients and expectation of cooperation were difficult to communicate to attendants.

Motivation techniques. Attendants who know a patient well can often motivate him to a remarkable degree. However, for the patients they did not know well, their motivation techniques are often too abrupt. One attendant on our project walked into the day hall of regressed patients, announced an activity to everyone in general, and concluded no one was interested when he obtained no response. Another attendant recently transferred to the ward wished to get patients in-

volved in duplicating samples of articles she had crocheted herself. In answer to her, "Would you like to make one?" came the inevitable "No," and her subsequent discouragement. After she came to know them, they liked her very much and she stimulated them to do a great deal.

Limit setting in a firm but matter-of-fact manner is sometimes difficult for attendants who cannot distinguish between an individual and his behavior, i.e., "You are bad because what you are doing is bad." Sometimes on our project they did not recognize limit setting by the research staff because no chastisement was involved. Being unable to remain firm but emotionally uninvolved, attendants often prepared for a tug of wills when confronted with a recalcitrant patient. On the other hand, one of them managed to set limits beautifully by removing herself from the field of battle, "You have to take a shower because today is Thursday, and Thursday is shower day!" However when an occupational therapist sees attendants treating patients as "bad," he should not commit the same error and regard the attendant, as well as his actions, as "bad."

Staff reactions. It is commonly supposed that an increase in staff automatically results in an improvement in patient care; however, an addition in personnel presents each individual with an addition in the number of interpersonal relationships with his co-workers and a confusing overlap in roles.[10] Our research ward was staffed with a greater number of attendants than other wards. Needless to say, a great deal of energy was required by the unusually high number of relationships with co-workers. Some shifts maintained rifts in their ranks throughout their four months together, with a corresponding decrease in productivity. Those groups that managed to integrate (which required considerable investment) were rewarded by intense satisfaction of working successfully together and seeing their patients improve. More patient disturbances seemed to occur when the "divided" groups were on duty. We found that a determined group of four or five could sometimes cope with one difficult and irresponsible member, but two such members generally prevented any successful integration. These observations imply that an increase in staffing calls for careful selection and accompanying measures to promote integration; that two people who collaborate successfully can accomplish more than five who do not.

Shift conflict, common in large psychiatric hospitals, often disrupts continuity in ward functioning. Shift conflict is more the rule than exception in psychiatric hospitals. It might be expected since there are few steps taken to promote shift cooperation. Verbal reports between shifts are not generally given on wards without nurses; and administration personnel have little contact with the evening shift. In addition, the physical facilities are shared in common by different shifts and an individual worker can never be sure he will find things the way he leaves them. Either he must give up caring about equipment he prizes or he must lock it up. Frequent complaints were heard in our hospital that the day shift locked up all the soap or that the evening shift locked up all the games. The conflict seems inherent in the set-up rather than in individual personalities. The existence of verbal reports and the nonexistence of locks between shifts are no doubt significant symbols of a good deal of cooperative effort. Since the ward atmosphere can change radically at 3:00 p.m., occupational therapy programs can be profoundly affected by shift interaction. When a therapist does encounter problems in this regard, he can realize that they are common, probably produced by the situation, and require considerable effort to solve. Instead of falling into the trap of taking sides, he may be able to provide some continuity between the shifts and to promote better communication.

Attendants' reaction to professional staff, including occupational therapists, is often negative, no doubt understandably so. The professional staff members spend much of their time in nice offices instead of barren wards. They may offer attendants little help with their most pressing problems and bestow little credit for helping patients improve. When they do try to offer help, it is likely to be resented because it is meaningless within the context of attendants' common sense philosophy. A common attitude is: "We know what you want — be nice and let the patients do as they want." Under the breath is mutttered, "We might as well give them our keys." When occupational therapists try to support attendants, we should react appropriately to their concerns and anxieties instead of attempting to impart what we think they should know.

Treatment concepts. Attendants' concepts of the purpose of patients "doing things" are often divergent from those of occupational therapists. Usually these concepts are correlated with concepts of psychiatric treatment in general. Hopefully, occupational therapists have some appreciation of the uniqueness of psychiatry, how it is different from general medicine. Attendants, on the other hand, often tend to regard psychiatric treatment within the framework of general medicine. The psychiatric attendant's origin, like that of the psychiatric hospital, has its roots in the area of general medicine. It seems that there are two concepts from that area which have carried over into psychiatry.

The first concept is that exotic forms of treatment are more potent than prosaic, everyday procedures. This idea even precedes the time of recorded history when magical rituals were relied upon to relieve physical suffering. We see the remnants of this way of thinking in our own society where the general public, for example, prefers special dietary preparations for weight-losing regimes rather than ordinary types of food chosen wisely. In keeping with this philosophy, attendants tend to rely on mysterious forms of treatment, such as medications, the effects of which they do not intricately understand. On our project we often heard comments such as, "She's getting better today. She took her medicine, you know," or "He's getting high. Let's get an order for sodium amytal." We seldom heard, "Someone should stay with her today; she's becoming upset," or "It's nice to see these patients talking together without any personnel being present."

The second concept carried over into psychiatry from general medicine is embodied in the idea that treatment consists of physical care, of concrete operations using concrete objects. Treatment is medicine, surgery, the application of special appliances, all of which lie within the physicians' domain. The attendants' domain is nursing care which, in his eyes, is giving baths, backrubs and taking temperatures. These ideas are not surprising since most people think in concrete terms.[1] Abstract "anxiety" is harder to conceptualize than is measles. Many attendants felt that they put in a better day's work on wards where they bandaged patients, made beds, etc. instead of interacting with patients, stimulating them to activity, or participating in staff meetings where people "just talked."

Along the same lines of thinking, in general medicine the treatment procedures are done "to" or "for" the patient to remove or diminish his pathology. Our project attendants tended to do concrete things "for" patients rather than helping them develop new skills. At picnics the women attendants had to be weaned away from fixing the food, while the men spent their time at parties moving furniture and carrying things. They often did not feel that more could be done for the patients, such as promoting patient-to-patient interaction, a more abstract task. If patients were asked to help with the tasks of preparation and cleaning up, they were usually the same reliable ones. Eventually some attendants did learn to involve more regressed and less reliable patients in simple tasks. Usually, the cleaning and food preparations were regarded by attendants merely as tasks to be completed rather than as devices for patients to learn skills in dealing with their environment. Unlike patients in general hospitals, chronic psychiatric patients *not only need removal of pathology but they also need to learn how to be or to act "well."*

Attendants' ideas concerning the benefit of activities to patients were not systematically explored on our project, but I feel they usually think that activities offer to patients what attendants' own leisure time interests offer to themselves: relaxation, enjoyment, a pleasant way to pass the time, a reward, a bit of transient happiness. Some project attendants seemed to feel that patient participation in activities and housekeeping functions were important. There were many others however who devoted much time and energy to stimulating patient activity without really knowing why, other than that the project staff expected it. They were handicapped by a vague sense that they were wasting time on trivial matters. Just as they felt that giving backrubs and taking temperatures were a legitimate form of work, they felt that participation with patients in talking and bingo and softball were relaxation and entertainment. A few attendants felt that the patients had too many activities (rewards, gifts) and that they should learn what hard work and life is really like.

RECOMMENDATIONS

Attendants generally think and talk in concrete terms and are not interested in abstractions. They will help a depressed patient plant flower seeds but pay no heed to the patient's comment that the flourishing flowers are "dead." They think of calisthenics as calisthenics, and do not appreciate patients' progress when they become better coordinated, imitate simple movements more easily, and learn to lead the group themselves. The symbolic meaning of activities generally does not interest them. The same may be said of patterns of patient-to-patient interaction.

View problems in proper context. An occupational therapist seeking to extend himself through attendants should realize he is dealing with hospital social structure and attendant culture. His task is not an easy or casual one. It requires thought and planning and time. He cannot be expected to dash onto a ward, conduct some proceedings and run off again. The dynamics of ward change are as complicated as the psychodynamics of individual patients. Progress is not made, as stated by Redlich, by "rushing into frantic activity and total push therapy but (by) a thoughtful analysis of the hospital social system and a clarification of roles."[3]

An individual therapist cannot do this all himself, but he can recognize his limitations and those of attendants, get the most out of his potential and that of attendants, thoughtfully deal with

personnel resistance, enlist and promote support from appropriate figures in the administrative hierarchy, maintain some semblance of objectivity, and collaborate with administrators trying to make progressive changes.

Act as consultant. An occupational therapist who can spend only small amounts of time on a ward and who is considered an outsider by ward personnel might do well to remain an outsider, i.e., a consultant to attendants. Rather than expecting an attendant to fit in with his program, as a consultant he can help attendants with theirs. A consultant's client is essentially in command of the situation, just as the attendant is essentially in command of the ward. *Attendants invest far more in projects they initiate than in ones imposed upon them.* An occupational therapist must learn to relinquish his satisfactions obtained from his own relationships with patients in favor of satisfaction gleaned from noting improvement in attendant functioning. Resistance and problems of attendants are appropriate areas of concern and should not be regarded as nuisances to be dispensed with as quickly as possible. A consultant must make himself useful to his clients in order to be consulted. For the occupational therapist this can be a very difficult task. It would seem that the only way to begin is for the occupational therapist consultant to make himself useful to attendants in ways meaningful to them. In other words, they must be met on their level.

Distribute supplies. Occupational therapy departments are not uncommonly regarded by attendants as supply reservoirs. During contacts with our follow-up wards in the project, the occupational therapy department was never mentioned by attendants in any other context. An occupational therapist who can obtain paint requested for a ward redecorating project or who can cut red tape in arranging for a bus will be performing useful tasks in the eyes of an attendant requesting these things. The distribution of equipment and supplies is a complicated issue and a double-edged one. On the one hand, if many people have access to them, they tend to disappear. Attendants have difficulty keeping supplies in an office shared by many others. On the other hand, if the distributor is anxious, the supplies disappear even faster. In one hospital, the fancier and more specialized the lock, the more it was violated. On our project, the supplies were kept in the occupational therapist's office to which all attendants had keys. They were encouraged to use the facilities and assumed the corresponding responsibilities well. However, some of the woodworking tools originally kept in the attendants' office vanished. When the remaining ones were transferred to the occupational therapist's office, a still accessible place, they stayed around much longer. It was felt that an elaborate checking system would have completely discouraged their use.

Often supplies are not more widely distributed to attendants because of occupational therapists' built-in anxieties about waste and poor use of them. Yet it would seem desirable to work with this issue rather than to withdraw supplies completely. Attendants already occupy the lowest rung in the hospital heirarchy and their difficulties in obtaining "things" must enhance their feelings that they are held in low esteem. Only when the obtaining of supplies ceases to be an issue are attendants likely to appreciate the fact that there are other things more important in working with patients. We must learn to thread our way carefully through this maze of problems.

Another way for an occupational therapist to establish his usefulness is to be primarily supportive of attendants having difficulties with patients. An attendant who treats a patient unwisely does so out of fear and anxiety of his own. Without sanctioning his actions, occupational therapists can offer a sympathetic attitude and some understanding of his feelings. This is difficult to do when our natural inclination is to reach out to the patient we feel has been treated antitherapeutically. We can't expect attendants to have worked through all their feelings about incontinence, masturbation, homosexuality, insubordination, aggression, etc.[6] On our project we noted several times that a negative attendant-patient relationship was converted into a positive one when we supported the attendant and did not attempt to come between him and the patient. This observation is in keeping with observations of Stanton and Schwartz. In fact a negative relationship between attendant and patient can present more therapeutic possibilities than an indifferent relationship.

Arouse interest. Occupational therapists can also make themselves useful to attendants by encouraging them to share their own interests with patients. On our project, the most successful activities were those enjoyed by attendants in their private lives. The patients benefited from them and their extensive participation was no doubt due to the attendants' enthusiasm. Nursing care, administrative duties and constant interruptions demand much of an attendant's energy. Patient activities which offer him relaxation and enjoyment enlist his investment more readily than those which do not. I see nothing wrong in using these phenomena constructively, especially as a beginning, in changing ward milieu. We don't wish to perpetuate the idea that activities are primarily for attendants, but we can encourage them to share their interests with patients. These interests are more likely to

be concrete ones such as sports, games and needlework rather than verbal ones such as current events discussions. Lacking the occupational therapist's philosophy of make-do and improvisation, male attendants especially are strongly inclined toward the use of regulation sports equipment and will often neglect that which is non-regulation. Activities which attendants dislike we might well accept as taboo. For example, if painting and drawing is considered "kid-stuff" by an attendant, he will rarely be convinced otherwise, and then only after he has developed a tremendous respect for the would-be convincer. If drawing and painting are initiated on the ward by the therapist, the patients will be influenced by the attendant's negative attitude. Some attendants may eventually learn to do things on the basis of their meaningfulness to patients, but they won't begin that way.

One concept that attendants can appreciate and utilize is the development of patient responsibility. So many activities are presented ready-made to patients who will sit quietly waiting for refreshments to be deposited in their outstretched hands or who are unexpectedly herded onto a bus for a field trip. It takes months to get chronic patients to the point where they can make decisions or suggestions concerning their activities and assume responsibilities for them, but attendants can help them do these things. Patient events can be expanded, i.e., instead of pre-arranging a field trip which the patients "take" for two hours, attendants can discuss the possible destinations with the patients, spend considerable time over personal grooming, discuss the trip afterward, and have a patient write about it for their newspaper.

Consulting as described here may sound like, "Be nice to the attendant and let him do as he wants." On the contrary, the therapist does not abdicate his good judgement. Occasionally, he will be confronted with grandiose and unrealistic schemes, good intentions with nothing behind them, and wasteful use of supplies. Sometimes a good way to get an attendant to comprehend the folly of his ideas is to ask him to spell out the details and results. His resistance to a suggestion may be clarified to the therapist who obtains his fantasies about it.

Provide figure for identification. It has already been mentioned that attendants mature as therapeutic agents through identification with proper figures rather than by merely being exposed to didactic training. An occupational therapist who helps and supports an attendant in terms meaningful to him can provide such a figure. Obviously all attendants will not identify with him but clearly all disciplines must help in this respect when the primary responsibility for patient care is thrust on attendants. If professionals cannot reach all patients, they must extend their influence through attendants instead of trying to come between the two groups. Attendants cannot be expected to "give" to patients unless we "give" to them.

SUMMARY

Some of the difficulties of occupational therapists working with attendants in large psychiatric hospitals are discussed. Problems are viewed in relation to the social structure of the hospital and to some characteristics of the attendant population. It is recommended that occupational therapists modify their roles from the expert who expects attendant cooperation to that of consultant who supports attendants in common sense terms meaningful to them.

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PERFORMANCE REQUIREMENTS IN OCCUPATIONAL THERAPY*

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One of the most important and difficult functions of the supervisor is the evaluation and counseling of the people he supervises. At the same time, probably one of the greatest rewards for the supervisor is the successful development of subordinates into satisfied and productive employees. This requires a systematic review and evaluation of the employee's performance at regular intervals. This periodic review may be done on a casual or a formal basis, but it must be done. How else can you expect subordinates to give good performance if they do not know specifically where their performance is poor and how it may be improved?

This performance evaluation requires more emotional energy than time. As a result, it is easy for the supervisor to hide behind paper work to avoid these difficult and trying personnel responsibilities. It is not surprising that the soft-spoken person who is most familiar and sensitive to the elements of satisfactory human relations finds the counseling interview most difficult. This holds true in most personal relations, generally people "suffer in silence" or offer veiled hints rather than face a frank discussion concerning behavior annoyances.

PRINCIPLES OF EVALUATION INTERVIEW

In order to conduct a successful evaluation interview with an employee it is essential that the supervisor be as objective, honest and sincere as possible. At the same time it is important that the employee, (1) feels that the supervisor is "on his side," (2) knows what can be done to correct the situation when criticized, (3) feels confident that rewards will be given when justified, (4) knows when he is in real danger.

OBJECTIVES OF RATING

The performance rating or evaluation can serve many purposes: The National Industrial Conference Board in a survey of ninety-four companies compiled the following list of objectives:

1. To help in deciding who should be promoted, demoted or given a raise in pay.
2. To discover worker's weaknesses as a basis for planning training.
3. To uncover exceptional talents.
4. To furnish a basis for discharge of totally unfit employees.
5. To help top supervisors learn how each person is appraised by his foreman.
6. To help top supervisors judge the fairness, severity or leniency with which supervisors judge their people.
7. To help in assigning work in accordance with worker's ability.
8. To serve as a check on employment procedures generally and interviews and tests specifically.
9. To stimulate people to improve.
10. To develop people's morale through stimulating confidence in management's fairness.

A rating plan need not encompass all these objectives . . . yet merit rating could serve as a basis for counseling employees about their strengths and weaknesses or improving supervisory-employee relations.[1]

It stands to reason that if grievances exist or if employees have shortcomings, they cannot be reduced or removed simply by waiting. Sooner or later the matter must be discussed.

In setting up performance requirements in occupational therapy at VA Hospital, Hines, Illinois, we used an approach described in an article, "Skills of an Effective Administrator," by Robert L. Katz[2] who suggests that performance depends on fundamental skills rather than personality traits. The basic skills mentioned in this article also seem to apply to the occupational therapist at any level, staff or supervisory. The three skills are *technical, human* and *conceptual*. The relative importance of these three skills will vary with the level of supervisory responsibility.

As applied to the occupational therapist these skills may be defined as follows:

Technical skill. This refers to the understanding of basic theoretical, medical and psychological knowledge as well as proficiency in the methods, procedures and techniques related to the application of these skills.

Human skill. This is the ability, so important to the occupational therapist, to understand and relate well with his patients and co-workers, and to function maturely in difficult situations.

This skill may also be demonstrated in the way "the individual perceives (and recognizes the perceptions of) his supervisors, equals and subordinates, and in the way he behaves subsequently."[2]

Conceptual skills. An effective occupational therapist at any level must be resourceful and creative and must be able to see individual and collective problems and to plan accordingly. This

*The opinions herein expressed are those of the author and not necessarily those of the Veterans Administration.

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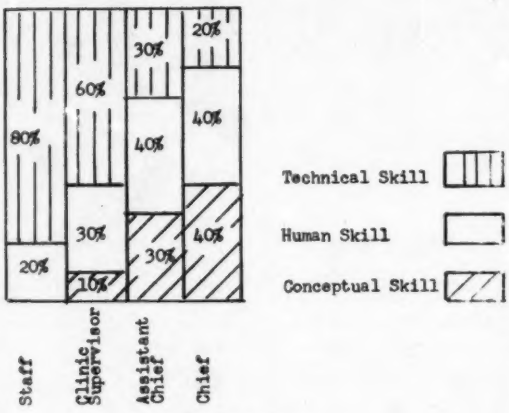

TABLE I

is as important for the staff therapist as for the clinic director. However, as the therapist acquires increasing administrative responsibilities, these conceptual skills become proportionately more important. In this sense, the overall conceptual abilities of the clinic director become a major element in the performance of his duties. "Competent planning draws heavily upon creativeness and the ability to put together a basic format of required activities."[3]

FORMULATING THE REQUIREMENTS

We stated earlier that the relative importance of these three skills varies with the level of administrative responsibility. This is best described by Katz. Although the author is referring to an industrial situation, his statements can be applied to the working occupational therapist.

> Human skill, the ability to work with others, is essential to effective administration at every level. One recent research study has shown that human skill is of paramount importance at the foreman level, pointing out that the chief function of the foreman as an administrator is to attain collaboration of people in the work group . . . And still another study, concerned primarily with top management, underscores the need for self-awareness and sensitivity to human relationships by executives at that level. These findings would tend to indicate that human skill is of great importance at every administrative level, but notice the difference in emphasis.
>
> Human skill seems to be most important at lower levels, where the number of direct contacts between administrator and subordinates is greatest. As we go higher and higher in the administrative echelons the number and frequency of these personal contacts decrease, and the need for human skill becomes proportionately, although probably not absolutely, less. At the same time, conceptual skill becomes increasingly more important with the need for policy decisions and broad-scale action. The human skill of dealing with individuals then becomes subordinate to the conceptual skill of integrating group interests and activities into a coordinated whole . . .
>
> It would appear then, that at lower levels of administrative responsibility, the principal need is for technical and human skills. At higher levels, technical skill becomes relatively less important while the need for conceptual skill becomes the most important skill of all for successful administration. A chief executive may lack technical or human skills and still be effective if he has subordinates who have strong abilities in these directions. But, if his conceptual skill is weak, the success of the whole organization may be jeopardized.[2]

Keeping these factors in mind we attempted to develop performance requirements for each of the four levels of positions in the occupational therapy section, physical, medicine and rehabilitation service, at VA Hospital, Hines, Illinois. These positions are: staff occupational therapist; clinic and student supervisor; assistant chief, occupational therapist (supervising three to four occupational therapy clinics), and chief, occupational therapist. The entire staff assisted in writing the requirements, each for his own position.

We listed ten basic elements for each position and divided each of these elements into characteristics or sub-elements (see appendices). It developed that 80 per cent of the staff therapists' position requirements are in the area of technical skills and 20 per cent in human skills. Creative ability is not a major element for the staff therapist, but is covered in several of the sub-elements. What is considered a sub-element here (displays personal and professional growth by studying new and old techniques) becomes a major element in all higher grades.

Whereas the staff therapist is expected to possess medical and technical knowledge to treat patients, the supervisor not only should possess the same knowledge, but in addition is expected to correlate this knowledge with other therapies within the hospital. The assistant chief extends this same knowledge to correlation with other therapies, services and agencies both within and beyond the hospital. Another subtle difference is expressed in the fact that the staff therapist is asked to *accept assigned responsibilities* whereas the supervisor is expected to *assume responsibility and initiate action.*

The relative weighting of the three basic skills (technical, human, creative or conceptual), at different position levels are shown in Table I. Again the decrease in technical abilities does not mean that the high level supervisor should not fully possess these skills, but rather that in the exercise of his administrative duties, the ability to plan and coordinate become proportionately more important.

USE OF PERFORMANCE REQUIREMENTS

Each employee at this hospital receives a performance rating at least once a year; and more often, when needed. These particular requirements with minor revisions have been used for the past three years and have proved to be an

(*Continued on Page* 255)

OCCUPATIONAL THERAPY
PERFORMANCE REQUIREMENTS
STAFF

Superior | Satisfactory | Needs Improvement

TECHNICAL SKILLS — REMARKS

Name:

Date:

1. Possesses technical skill and basic knowledge of medical, psychological and theoretical subjects required in treating patients in all diagnostic groups.

— — — a. Applies theoretical knowledge appropriately in clinic situation.
— — — b. Uses diversified range of available activities.
— — — c. Considers all pertinent factors in planning individual treatment programs.
— — — d. Uses ingenuity and common-sense in making adapted devices.
— — — e. Displays personal and professional growth by study and attempts to increase scope of experience.

2. Properly applies skills and plans an effective treatment program.

— — — a. Considers all physical and psychological factors in planning individual treatment program.
— — — b. Alert to patient's changing needs and precautions to be observed.
— — — c. Attempts to adapt activities to improve treatment.
— — — d. Works with a minimum of technical guidance.
— — — e. Utilizes information from other departments when indicated.

3. Maintains professional and therapeutic relationship with patients and deals effectively with various attitudes.

— — — a. Presents prescribed treatment to patients in clear, understandable manner.
— — — b. Manner is in keeping with professional situation.
— — — c. Adjusts approach to meet patient's needs.
— — — d. Deals effectively with resistive attitudes of patients.
— — — e. Maintains friendly, but objective attitude wtih patients and uses discretion in conversation.

4. Uses judgment in analyzing situations, grasping essentials and planning necessary steps in accordance with priorities.

— — — a. Observes all safety precautions.
— — — b. Appraises situations realistically; sees things in proper porportion.
— — — c. Follows rules and regulations of department.
— — — d. Keeps supervisor informed of professional needs, ideas and goals.
— — — e. Adjusts to working situation.

5. Accepts assigned responsibilities, assumes responsibility in emergencies.

— — — a. Considers all factors in emergency situations, makes quick and accurate decisions, acting accordingly.
— — — b. Displays initiative and judgment in absence of supervisor.
— — — c. Does not require supervision to keep on the job.
— — — d. Reports for work on time and starts work promptly.
— — — e. Does not abuse sick leave, able to perform duties without complaint.

6. Possesses orderly work habits and is responsible for the care of equipment and work area.

— — — a Guards against loss or breakage of occupational therapy tools and equipment.
— — — b. Notifies supervisor concerning safety hazards and necessary repairs or replacements.
— — — c. Budgets own time effectively.
— — — d. Accepts fair share of responsibility for maintaining clean and orderly clinic area.
— — — e. Maintains hand and power equipment at adequate working level.

7. Requests for supplies and equipment are realistic and practical.

— — — a. Improvises or utilizes what is on hand when practical.
— — — b. Bases choice of equipment and material on basic supply and demand.
— — — c. Regulates quantities of supplies to meet actual therapeutic need, with due consideration to economy.
— — — d. Investigates and utilizes improved activities.
— — — e. Assists supervisor in keeping volunteer task list and supply needs current.

8. Reports are accurate, clear, concise and within deadlines.

— — — a. Progress notes and discharge summaries emphasize appropriate information in a brief, concise manner.
— — — 8. Progress notes are kept up-to-date and discharges are completed promptly.
— — — c. Notes are legible and correct as to grammar, spelling and medical terminology.
— — — d. Accurate measurements (joint motion, pulse, A.D.L., muscle strength, etc.) are reported regularly.
— — — e. Discusses occupational therapy aims and objectives effectively with physiotrist and ward physician.

HUMAN SKILLS

9. Shows maturity in appraising situations, flexibility in making changes and receptive to constructive suggestion.

— — — a. Cooperative with co-workers, loyal to department.
— — — b. Flexible in adjusting to changes.
— — — c. Shows mature judgement in appraising situations, seeing all factors in proper proportion.
— — — d. Subordinates personal affairs to needs of department, (i.e., annual leave requests, etc.).
— — — e. Receptive to constructive suggestions, recognizes and attempts to overcome personal weaknesses.

10. Displays poise and tact in dealing with patients and personnel, able to develop acceptable interpersonal relationships with patients, allied personnel and visitors.

— — — a. Develops acceptable interpersonal relationships with all.
— — — b. Displays poise and sensitivity in dealing with patients.
— — — c. Uses every opportunity to improve occupational therapy public relations with personnel and visitors.
— — — d. Possesses pleasant, alert and well groomed appearance.
— — — e. Actions are in keeping with professional situation.

OCCUPATIONAL THERAPY
PERFORMANCE REQUIREMENTS
SUPERVISOR

Superior	Satisfactory	Needs Improvement	TECHNICAL SKILLS	REMARKS
			1. Correlates medical and technical knowledge to solve rehabilitation problems (devising adapted tools and equipment, correlating treatment with other therapies).	
—	—	—	a. Applies theoretical knowledge appropriately in the clinic situation.	
—	—	—	b. Is constantly alert to the treatment possibilities of a diversified range of available materials.	
—	—	—	c. Correlates treatment with other therapies, such as awareness of the functions of physical therapy, educational therapy, social work service, etc.	
—	—	—	d. uses ingenuity and common sense in making necessary adaptations.	
—	—	—	e. Takes an active role in maintaining effective working relationships with other departments.	
			2. Evaluates the patients carefully and plans an affective treatment program.	
—	—	—	a. Considers all significant physical and psychological factors in planning individual treatment programs.	
—	—	—	b. Long range planning shows balance between idealistic goals and realistic limitations.	
—	—	—	c. Periodically re-evaluates patients for changing needs and precautions to be observed.	
—	—	—	d. Establishes rapport with difficult patients.	
—	—	—	e. Meets unusual problems arising in the rehabilitation of the severely disabled patient.	
			3. Develops study projects related to treatment activity.	
—	—	—	a. Willingly participates in study projects as set up by hospital or state or national occupational therapy association.	
—	—	—	c. Keeps abreast of new ideas and changes in profession by study and personal contacts.	
—	—	—	d. Introduces and carries through new ideas in maintaining a progressive treatment program.	
—	—	—	e. Actively shares new techniques and ideas through written or verbal reports.	
			4. Assumes responsibility of directing a progressive student training program.	
—	—	—	a. Carefully plans and revises program when necessary to assure students receive most worthwhile experiences that clinic and ward situation has to offer.	
—	—	—	b. Keeps assistant chiefs and chief of occupational therapy, appraised of progress and potentials of all students.	
—	—	—	c. Uses teaching opportunities as they arise in daily situations.	
—	—	—	d. Grades all students objectively and fairly.	
—	—	—	e. Assumes responsibility for guiding students in professional and ethical behavior.	
			5. Reports are accurate, clear and within deadlines.	
—	—	—	a. Progress notes and other reports emphasize appropriate information in a brief, concise manner.	
—	—	—	b. Clinic progress notes are up-to-date; discharges completed promptly.	
—	—	—	c. Thoroughly reviews all work, checking details and noting errors.	
—	—	—	d. Uses medical termniology appropriately and expresses self simply and directly.	
—	—	—	e. Effectively discusses clinic and patient needs with physiatrist and/or appropriate personnel.	
			6. Bases requests for supplies and equipment with a realistic view of basic needs, reports necessary repairs for safe maintenance of equipment.	
—	—	—	a. Regulates quantity of supplies to meet actual therapeutic need with due consideration to economy.	
—	—	—	b. Submits carefully thought out budget requests on time; requests supplies for new activities when indicated.	
—	—	—	c. Guards against breakage and loss of tools or equipment.	
—	—	—	d. Observes safety precautions and anticipates repair needs.	
—	—	—	e. Improvises or adapts what is on hand when practical.	
			HUMAN SKILLS	REMARKS
			7. Sees that professional and therapeutic atmosphere of clinic is maintained.	
—	—	—	a. Provides an effective example of professional attitude and behavior for patients, students, volunteers and visitors to clinic.	
—	—	—	b. Takes all necessary steps to see that professional and therapeutic atmosphere is maintained by others in the clinic area.	
—	—	—	c. Is effective in promoting morale of colleagues.	
—	—	—	d. Deals effectively with resistive attitudes of patients, displaying sensitivity and tact toward all.	
—	—	—	e. Reacts realistically and objectively in appraising and dealing with difficult situations.	
			8. Possesses poise and ability to express ideas and discuss occupational therapy aims with physicians and allied peronnel, and improves public relations whenever possible.	
—	—	—	a. Effectively discusses occupational therapy program with physicians and allied personnel.	
—	—	—	b. Represents occupational therapy as a professional member of the medical team whenever possible at ward rounds, team meetings, conferences or other pertinent medical meetings.	
—	—	—	c. Is poised and sensitive in dealing with other department personnel as well as patients.	
—	—	—	d. Displays integrity and loyalty to co-workers and hospital organization.	
—	—	—	e. Uses every opportunity to improve public relations.	
			9. Dependable and reliable in executing responsibilities; shows good judgment in delegating assignments.	
—	—	—	a. Obeys all rules and regulations; follows proper channels (i.e., requests, suggestions).	
—	—	—	b. Accepts responsibility willingly; is dependable in fulfilling and delegating assignments.	
—	—	—	c. Subordinates personal affairs and prejudices where necessary for the good of the program.	
—	—	—	d. Physically able to perform duties without complaint, does not abuse sick leave; reports to work on time.	
—	—	—	e. Functions effectively and maturely under pressure.	
			CONCEPTUAL SKILLS	
			10. Seeks personal and professional growth; attempts to increase scope of experience.	
—	—	—	a. Participates in meetings and conferences; recognizes need for an exchange of ideas in a growing profession.	
—	—	—	b. Actively supports state and national occupational therapy associations.	
—	—	—	c. Accepts constructive criticism; recognizes and tries to correct personal weaknesses.	
—	—	—	d. Plans and carries out program for personal and professional self-development.	
—	—	—	e. Is creative in planning toward improved program.	

OCCUPATIONAL THERAPY
PERFORMANCE REQUIREMENTS
ASSISTANT CHIEF

Superior	Satisfactory	Needs Improvement	
			TECHNICAL SKILLS
			1. Correlates medical and technical knowledge in solving unusual rehabilitation problems (devising adapted tools or equipment, correlation with other therapies and agencies).
—	—	—	a. Applies theoretical knowledge and experience; appropriately advises supervisor concerning treatment of the severely disabled patient.
—	—	—	b. Shows knowledge, skill and techniques necessary to devise special adaptations and tools for all types of disabilities.
—	—	—	c. Correlates treatment with physiatrist, medical staff, other therapies and services to facilitate a team relationship.
—	—	—	d. Has sufficient understanding of inter-hospital department functions to draw on these facilities when necessary.
—	—	—	e. Keeps chief of occupational therapy appraised of situations concerning occupational therapy relationships with other departments to ensure a continual smooth running organization.
			2. Reports are accurate, clear, and concise and within deadlines.
—	—	—	a. Maintains appropriate department records and information is readily available.
—	—	—	b. Prompt in completing accurate assignments.
—	—	—	c. Expedites special requests for supplies, work orders, etc.
—	—	—	d. Memoranda, correspondence and informal communications present ideas clearly concisely and effectively.
—	—	—	e. Reviews all work for accuracy, seeing that progress notes, discharges, and other reports are up-to-date.
			3. Evaluates supply needs; quarterly requisitions are consistent with treatment needs and available funds.
—	—	—	a. Budget and equipment requests are consistent with treatment needs, available funds and materials at hand.
—	—	—	b. Carefully evaluates treatment needs and establishes supply levels.
—	—	—	c. Investigates new media and techniques and initiates use of same.
—	—	—	d. Guards against waste, breakage or loss and anticipates repair needs.
—	—	—	e. Maintains current and accurate budget accounts.
			HUMAN SKILLS
			4. Shows good judgment in delegating authority and tact and sensitivity in all relations with co-workers.
—	—	—	a. Shows good judgment in delegating authority making the best use of available manpower; supports co-workers when necessary.
—	—	—	b. Displays poise and sensitively in dealing with personnel, patients and other departments.
—	—	—	c. Keeps chief of occupational therapy appraised of progress and potentials of all students for more effective recruiting.
—	—	—	d. Counsels staff regularly concerning performance and keeps chief informed of staff accomplishments and problems.
—	—	—	e. Maintains generally high morale in occupational therapy section by fair and understanding supervision.
			5. Able to express ideas effectively; discusses occupational therapy aims with physicians and allied personnel; uses every opportunity to improve public relations.
—	—	—	a. Possesses poise and ability to express ideas effectively to individuals and groups.
—	—	—	b. Uses every opportunity to improve public relations for the occupational therapy section.
—	—	—	c. Takes an active role in maintaining constant and effective liaison with physiatrists and residents assisting them whenever possible, to achieve the full potentials of occupational therapy.
—	—	—	d. Sees that professional conduct of staff and students is maintained.
—	—	—	e. By pleasant, alert and assured manner inspires confidence and respect of co-workers and allied personnel.
			6. Unit is a smooth running organization, has good morale, able to adjust to necessary changes in routine.
—	—	—	a. Foresees emergencies and avoids bottlenecks by efficient planning and scheduling.
—	—	—	b. Displays sufficient flexibility to adjust to necessary changes.
—	—	—	c. Budgets time so as to supervise all staff and clinic routinely, spending extra time supervising areas which need greater help.
—	—	—	d. Maintains generally high morale of unit by awareness of personnel problem and solving such problems promptly.
—	—	—	e. Keeps abreast of clinic routines to maintain patient treatment during absence of regular therapists.
			7. Dependable and reliable in executing assigned responsibilities; displays integrity and loyalty toward hospital organization and co-workers.
—	—	—	a. Dependable in fulfilling duties and completing assignments. Subordinates personal plans to meet the needs of the hospital.
—	—	—	b. Interprets hospital regulations and personnel policies and sees that they are carried out.
—	—	—	c. Displays integrity and loyalty toward hospital organization and co-workers.
—	—	—	d. Maintains unity of organization by accepting guidance of chief of occupational therapy for full coordination of program.
—	—	—	e. Physically able to perform duties without complaint.
			CONCEPTUAL SKILLS
			8. Displays vision and initiative in inaugurating plans, operations and study projects, keeping in mind the overall welfare of the department.
—	—	—	a. Actively shares new techniques and ideas through written or verbal reports.
—	—	—	b. Promotes new investigations and analyzes existing treatment problems to maintain a progressive occupational therapy unit.
—	—	—	c. Encourages individual initiative and builds confidence in co-workers to inaugurate new plans and procedures.
—	—	—	d. Displays vision and creativity in planning toward an improved program.
—	—	—	e. Plans and suggestions show understanding of unit and organiaztional inter-relationships.

REMARKS

9. Cognizant of student training standards; attempts to raise level of specific training areas.

— — — a. Sees that responsible supervisors maintain a progressive student program.
— — — b. Aware of responsibility to profession and hospital in using teaching opportunities as they arise in daily situations for training future therapists and supervisors.
— — — c. Makes careful evaluation of student as a potential employee. Keeps chief informed of individual student's progress.
— — — d. Counsels supervisors to insure fair and objective grading.
— — — e. Maintains American Occupational Therapy Association standards and attempts to raise level of training in specific areas when necessary.

10. Seeks personal and professional growth, avails self of every chance to increase scope of experience.

— — — a. Plans and carries out program for personal and professional self-development.
— — — b. Seeks growth through study and increasing scope of professional experience.
— — — c. Participates in meetings and conferences and disseminates pertinent information to staff.
— — — d. Accepts constructive criticism or suggestions, recognizes and tries to overcome personal weaknesses.
— — — e. Actively supports state and national occupational therapy associations.

OCCUPATIONAL THERAPY
PERFORMANCE REQUIREMENTS
CHIEF

Superior | Satisfactory | Needs Improvement

TECHNICAL SKILLS — REMARKS

1. Correlates medical and technical knowledge in solving unusual rehabilitation problems (devising adapted tools or equipment, correlation with other therapies.)

— — — a. Utilizes theoretical knowledge and experience in adapting equipment or in advising occupational therapy personnel concerning treatment procedures for the severely disabled patient.
— — — b. Applies basic principles of medical and technical training in setting therapeutic goals for the severely disabled patient.
— — — c. Maintains working liaison with physical medicine and rehabilitation sections, physiatrist, and medical staff to facilitate a team relationship.
— — — d. Has sufficient knowledge of allied rehabilitation agencies to utilize their resources.
— — — e. Works harmoniously with all hospital services toward the patients' complete medical rehabilitation.

2. Dependable and reliable in executing assigned responsibilities; reports are accurate, clear, concise and within deadlines.

— — — a. Checks work progress and quality of clinic and ward activities by making frequent and thorough review of therapists' schedules, patient load and treatment reports.
— — — b. Provides and devises methods of expediting work of co-workers by improving procedures and removing bottlenecks.
— — — c. Reports are accurate, clear, concise and within deadlines, correspondence is handled promptly and efficiently.
— — — d. Dependable in fulfilling duties, and completing assignments and physically able to perform these duties without complaint.
— — — e. Keeps coordinator and chief of physical medicine and rehabilitation service appraised of situations concerning occupational therapy relationships with other divisions and services to ensure a smooth running organization.

HUMAN SKILLS

3. Possesses the understanding, discernment and judgment to counsel co-workers when necessary to prevent or to solve personnel problems and maintain high morale within the occupational therapy section.

— — — a. Maintains the active cooperation of associates in long range planning to improve department.
— — — b. Anticipates, avoids and/or attempts to solve conflicts by considering pertinent factors, determining solution, and correlating activities of individuals or units within the occupational therapy section.
— — — c. Displays an awareness of personnel problems, a willingness to listen thereto patiently and an ability to solve such problems and settle grievances without delay.
— — — d. Keeps chief of physical medicine and rehabilitation service and coordinator informed concerning potentials of occupational therapy staff for advancement.
— — — e. Maintains generally high morale in occupational therapy section by fair and understanding supervision and supporting them when justified.

4. Maintains an effective liaison between the chief of physical medicine and rehabilitation service and the occupational therapy staff. Displays integrity and loyalty toward the hospital organization and tact and sensitivity toward the needs of co-workers.

— — — a. Employs self-control, tact and poise in difficult situations when conflicting opinions could disturb harmonious relationships with patients or personnel.
— — — b. Aware of space, personnel and equipment needs of the program and effectively represents the occupational therapy section in requesting additions or changes.
— — — c. Keeps co-workers currently posted on objectives, policies, plans and progress of overall program.
— — — d. Displays integrity and loyalty to hospital organization as well as co-workers.
— — — e. Maintains constant and effective liaison between the chief of physical medicine and rehabilitation service and occupational thrapy staff.

5. Displays judgment in selecting new staff members; grooms them for advancement to maintain a well balanced staff.

— — — a. Makes staff assignments and reassignments with due regard to capabilities of therapists in order to benefit the patient and maintain the morale of therapists.
— — — b. Shows good judgment in delegating authority and backs up co-workers to whom authority has been given.
— — — c. Displays insight and sound judgment in selecting new staff members.
— — — d. Promotions within the occupational therapy section are made with due regard to ability and merit.
— — — e. Maintains active in-service training program to prepare qualified staff therapists for advancement.

6. Possesses poise and ability to express ideas and effectively represent physical medicine and rehabilitation at the hospital.
- — — a. Possses poise and ability to express ideas effectively to individuals and groups.
- — — b. Succeeds in accomplishing objectives of interviews with patients and conferences with fellow workers and personnel of other services.
- — — c. Inspires confidence and respect for the physical medicine and rehabilitation service in contacts with medical personnel, other hospital services or visitors.
- — — d. Memoranda, correspondence and informal communications present ideas clearly, concisely and effectively.
- — — e. Uses every opportunity to improve public relations for occupational therapy section and physical medicine and rehabilitation service.

CONCEPTUAL SKILLS

7. Displays vision and initiative in foreseeing emergencies, inaugurating plans, operations and study projects, keeping in mind the overall welfare of the department and the hospital.
- — — a. Promotes new investigations and analyses of existing treatment methods to maintain a progressive occupational therapy section.
- — — b. Budget and equipment requests consistent with treatment needs and available funds.
- — — c. Displays vision and initiative in inaugurating plans, operations and study projects.
- — — d. Foresees emergencies and avoids bottlenecks by efficient planning and scheduling.
- — — e. Able to coordinate the occupational therapy section into an effective team and integrate all activities into the larger plan of the hospital organization as a whole.

8. Able to see all facets of a problem, weigh all possible solutions and accept the calculated risk when a decision is necessary.
- — — a. Ordinarily takes a reasonable chance when making a decision if the urgency of the situation forbids complete investigation of all contributing factors.
- — — b. Able to analyze situations, grasp essentials and reach sound conclusions and plan necessary steps in accordance with priorities.
- — — c. Understands the objectives and interrelationships with other activities and their relation to occupational therapy.
- — — d. Keeps chief of physical medicine and rehabilitation service informed of problems and accomplishments of the occupational therapy section.
- — — e. Able to accept responsibility for own mistakes; makes an honest effort to prevent such mistakes from recurring.

9. Maintains a progressive clinical affiliation program.
- — — a. Maintains a progressive clinical affiliation program for future therapists.
- — — b. Ensures a full understanding of occupational therapy by discussing functions and objectives with the physical medicine and rehabilitation service residents.
- — — c. Maintains American Occupational Therapy Association standards and attempts to raise level of training in specific areas.
- — — d. Effectively interprets benefits of Veterans Administration employment to students in recruiting potential therapists.
- — — e. Maintains active role in counseling and guiding students, moulding them into worthy therapists.

10. Seeks personal and professional growth for self and staff to maintain a progressive and effective occupational therapy program.
- — — a. Plans and conducts an in-service training program through demonstrations, conferences, films and slides.
- — — b. Maintains idealistic goals tempered by realistic planning to achieve these goals.
- — — c. Maintains an active interest in professional organizations.
- — — d. Plans and carries out program for personal and professional self-development.
- — — e. By strong leadership and choice of dynamic staff, maintains an occupational therapy section worthy of the medical and teaching standards of Hines hospital.

(*Continued from Page 250*)

effective counseling tool. They enable the supervisor to point out good points as well as areas that require improvement. The discussion of difficult and sometimes personal matters remains relatively objective and non-threatening to both supervisor and subordinate.

We have also found that these performance requirements can serve objectively in determining promotions. It is well known that promotions in Civil Service are based on merit. We have used these performance requirements in selecting the person best qualified to fill the position. In this case the individual is rated not for his own position, but for his potential in the higher position. Occasional administrative discrepancies become evident in this way. For example, the therapist who functions adequately by carrying out orders, but who hesitates to assume responsibility or who lacks the vision to see the organization as a whole should not be promoted to the supervisory position. The student and clinic supervisor, who is an excellent occupational therapist and teacher, able to meet the most difficult challenge in patient treatment, may on the other hand, neglect his reports or show a weakness in planning and delegating.

By attaching a simple numerical point system to each of the 50 items (1—*Satisfactory*, 2—*Superior*, and 0—*Needs Improvement*), all supervisors rate each employee who is eligible for the promotion. The chief and assistant chiefs rate the supervisors, and the supervisors rate the staff therapists. The promotion is based on the highest numerical grade after ratings from all supervisors have been compiled. It is felt that this is the most objective method possible for rating and selecting the proper candidates for promotion.

The "Performance Requirements," as written for our situation could easily be adapted to any occupational therapy department, whether located in hospital, university or rehabilitation center. It is possible they can be put to more uses than described here. At the very least, they should serve to clarify position responsibilities and to simplify counseling procedures.

ACKNOWLEDGEMENT

The author wishes to express her appreciation to W. T. Liberson, M.D., Ph.D., Chief, physical medicine and rehabilitation service, and the entire occupational therapy staff at V.A. Hospital, Hines, Illincis, for their assistance in formulating these performance requirements and suggestions concerning this paper.

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THE BROCKTON CERAMICS PROJECT

A Semi-Industrial Workshop

RUTH E. MOREHOUSE, O.T.R.*

The Brockton ceramic project is a medically prescribed semi-industrial occupational therapy program in which chronic psychiatric patients get paid for making ceramics which are sold to the public. Though unique in some aspects, like all other occupational therapy programs, it is prescribed only for therapeutic goals. It is not a sheltered workshop nor does it compete with private business. It is a therapeutic workshop using a new avenue of approach to the problem presented by that large group of chronic patients so difficult to motivate.

The occupational therapist must stay within the framework of his specialty. That is, he must use the handicrafts as his main tool and yet devise a *new method of approach* which will provide more effective motivation for the chronic patient than the traditional approach has done. Two ideas, i.e., payment for work and group oriented work, not original with us but relatively untapped in past activity programs, were combined with ceramics, a craft easily adapted to implement them. Chronic patients working in an inter-dependent group concentrated on making saleable pottery, are paid for their work.

Peffer[1] states "Research on value and incentives in our American culture has revealed one *major incentive* that forms a fundamental foundation of our way of life: *Money*. There is some experimental evidence that the monetary incentive incites more psychological, social, and personal motives in Americans than any other incentive in our culture. Monetary reward for socially acceptable and productive activity . . . makes the mental patient undertake normal behavior for normal rewards."

On this premise, the salary offered a patient in return for his particular work in the production of ceramics becomes the most universally satisfying reward he can earn. With his weekly pay envelope the long hospitalized patient regains one real-life situation which he finds good.

In our project no patient creates a piece of pottery from beginning to end. Only mold poured pottery is made. The highly structured nature of this craft makes it a particularly useful modality that can be broken down into individual operations which follow each other in orderly succession from one step to the next. Each of these operations becomes a specific job which is accomplished by patients who can perform at the pace and level required. This systematic, graded work flow consists of a variety of tasks extending from the plodding duties of cleaning or the crushing of chards, to the technical "know how" required in firing and glazing, and the painstaking and artistic hand decorating. This wide range of tasks makes possible many jobs suitable for chronic patients to perform.

For regulating and systematizing the pay scale, the graded work flow is arranged in the following categories:†

Grade I ($.50 to $.90 per week.) Sweep floors, clean cans, sinks, tables, crush chards, screen clay, etc.

Grade II ($.90 to $1.50 per week.) Trim and smooth bisque and/or greenware, clean molds, etc.

Grade III ($1.00 to $2.00 per week.) Stack kilns for bisque and/or glaze firing, inspect trimmed ware, watch time and record kiln firing time, empty kilns after cooling, grind and set out fired ware for final inspection, check stilts and shelves for kiln wash, etc.

Grade IV ($1.50 to $2.50 per week.) Detail and underglaze decorating, brush, dip and spray glaze, touch-up, prepare ware for glaze firing, mix glazes, etc.

Grade V ($2.00 to $2.75 per week.) Keep records such as inventory of supplies, finished ware, etc. Pack and deliver orders to special service or canteen, type, greet visitors, answer phone, etc.

The patient's wage is viewed not only as payment for work performed but also as an incentive for more normal behavior. When deciding whether or not a patient deserves a raise in pay, the occupational therapist gives first consideration to the amount of emotional improvement he may have shown. Even though a patient may show no particular increase in work skill, any real

*Chief, Occupational Therapy Section, Veterans Administration Hospital, Brockton, Mass.

The author wishes to thank those who have done so much to help make the Brockton ceramics project a success: Peter A. Peffer, M.D.; special service; The Veterans Administration voluntary service ceramics subcommittee; Bruce Fessenden O.T.R., Barbara Soule, O.T.R., and Thomas O'Donnell, O.T. aide.

†When government employees receive a pay increase, the same per cent increase is given patients in the project.

movement towards self-improvement may validate a pay raise for him. Usually emotional improvement and increase in work skill go hand in hand; however, emotional improvement has priority. Thus a patient has access to a pay raise if signs of emotional progress are recognized. Not every patient responds in the same way, but it is agreed that the cycle of progress can be stimulated with money in the form of pay or a raise in pay.

One of the evidences of emotional improvement has been the requests for social events, trips and parties coming directly from the patient group. These events do not need to be suggested or pre-planned by the staff; they are spontaneous requests from the patients who come up with "Let's have a picnic" or "When are we going on a trip?" As a result, several trips to museums, historical sites and ceramic shows have been taken, and numerous cook-outs and holiday parties enjoyed. This conscious effort towards group socialization is quite a solid achievement for chronically ill patients.

In this group-oriented, semi-industrial workshop we have made no particular effort to stress group interaction. The group atmosphere appears informal and comfortable. The coffee pot is always on and a patient may interrupt his work to have a cup of coffee. The first spontaneous group decision made was in favor of a "coffee kitty" to which patients would contribute from their earnings.

The program is structured to the needs and capacities of all patients assigned. Each patient has a definite role in the work process and this reality factor has always been kept in plain view. Many patients have acquired a sense of the value of participating, and some have shown a marked feeling of responsibility toward the project. Noticeable is the development of a group ego, a feeling of belonging, as each patient makes a contribution to the overall effort to produce saleable goods. The occupational therapy staff consists of a male and a female; conceivably for some patients this may have the value of family figures and experiences. We have also observed that being assigned to the project has contributed to patients' status needs. Admiration and praise are heard in abundance from the many visitors who come in; in fact no adverse comments are ever made. There is an old saying, "Nothing succeeds like success." (See Table I.)

It is interesting to report that the occupational therapists who have been assigned to supervise the project have also found gratification for one of their most pressing needs; i.e., a clarification of their professional role has developed.

The Brockton ceramics project was opened in September, 1955. Because government funds could not be used to purchase supplies and equipment or to meet the first patient payrolls, special service, through the Veterans Administration voluntary service (VAVS) committee, received $1,278 from voluntary organizations to get the project going. A VAVS ceramics project sub-committee was appointed consisting of two co-chairmen, a treasurer and a procurement officer. The treasurer and co-chairmen were duly bonded. A bank account was opened under the project's name with signature of one of the co-chairmen and the treasurer required on all checks. "The Brockton Ceramics Project" was chosen as the official title so that financial operation would in no way be identified with the Veterans Administration. Financially the project has never been in the red. Its first obligation, to replace in the bank account the initial $1,278, was accomplished with relative ease. From September, 1955, to December, 1960, a total of $7,836.98 has been paid out in patient salaries, and a small bank balance maintained as well.

The project's buying public consists almost entirely of individual volunteer workers, volunteer organizations affiliated with the hospital, patients and their families, and hospital staff who frequent the hospital canteen. Volunteers and their organizations may purchase at the project's stock room price; all other customers buy at the hospital canteen which charges a small legal mark up. The project has always wisely refrained from selling "seconds," thus keeping high quality something for patients to aim toward. Their reward comes from the praise of the customers.

TABLE I

Reason for Discontinuance from Project	1957	1958	1959	1960
Discharged with medical approval	15	24	25	20
Improved: Moving up to individual or member employee assignments	19	6	12	8
Physical illness	2	2	9	2
Refused to attend	1	2	2	4
Eloped from pass	..	3	..	..
Transferred to other hospitals	..	..	..	3
No improvement, transferred back to ward activities	9	20	21	11
Remaining in project at end of year	28	37	35	24
Total number assigned	**74**	**94**	**104**	**72**

SUMMARY

Money in the form of a weekly wage is an effective means of stimulating chronic psychiatric patients towards more normal behavior. A semi-industrial occupational therapy work shop, wherein each patient gets paid for performing a definite job on an interdependent production line which turns out saleable goods, provides a real-life situation; this reality aspect sets the tone for emotional improvement.

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A NEW LOOK IN ADL TEST EQUIPMENT

JANET ROBINSON, O.T.R.*

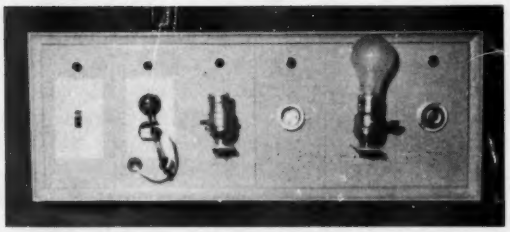

Figure 1. Showing six-module electrical simulator

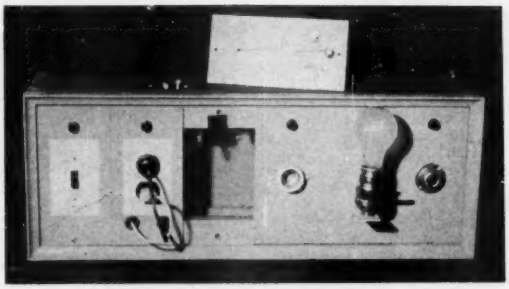

Figure 2. Showing one module removed to demonstrate interchangeability of modules and their independent wiring.

Frequently heard objections to the standard activities of daily living (ADL) board are that it takes up too much room and cannot be conveniently stored; the electrical components present shock hazards or are not functional; and out-of-date or unrealistic tasks do not hold adult interest. Through the design and construction of a set of ADL simulators, these objections have been overcome and new usefulness has been given ADL testing.

The set consists of a six-module electrical console, a single-module electrical console, and an eight-module mechanical console. This discussion is particularly concerned with the six-module electrical console, since it contains all of the design features included in the other consoles.

GENERAL DESCRIPTION

The console was designed to be professional and commercial in appearance yet within the budget and construction facilities of an occupational therapy department. It is approximately 25 inches by 9 inches by 7 inches in size. The front panel consist of six four-inch by eight inch interchangeable modules, i.e., aluminum plates on which test items have been mounted. A panel light mounted on each plate gives a visible response when the corresponding task is carried out, e.g., a button is pushed or a switch is turned on. The top, back and sides of the console are constructed of one-quarter inch plywood over a frame of one inch by one inch white pine and covered with upholstery plastic. The front panel is framed with one-half inch cove molding. The total cost of this console is under $20.00, though it could be constructed more economically with minor changes in materials used.

SAFETY FEATURES

In view of the real and imagined dangers associated with the use of electrical equipment, several safety features were built into this console. To eliminate the shock hazard from the 117 volt A.C. power source, the voltage was reduced to approximately six volts by the use of a step-down transformer. This same transformer also isolates the console from shock hazards that could occur from contact with grounded facilities, such as radiators or water pipes. Thus it is impossible to receive a shock from contact with any part of the console or the test items on it.

For additional safety, the practice light bulbs used with the console have been pierced through the base to destroy the vacuum. This precaution serves two functions. Since the bulbs will not light, there is no danger of burns from their heat; and without a vacuum an implosion cannot occur if accidently dropped and broken. It is considered important that a standard size bulb be used to assure realism in weight, feel and grasp. A panel light indicates whether a bulb has been screwed into the sockets, making the lighting of the bulb itself unnecessary.

ADAPTABILITY

The compactness and light weight of the console make it easily portable, though it is difficult to move or overturn in use. Often it can be carried to a patient's room or work area more easily than a patient can be moved to a stationary ADL board, and it can be stored conveniently when not in use.

For purposes of realism in testing, the console can be set on the floor to duplicate the height of actual wall plug receptacles. Similarly it can

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be raised to the height of actual floor and wall lamp switches and sockets. An extra long cord is provided for plugging the console into the house line or power source so that it can be comparatively mobile without the use of extension cords or numerous outlets.

The design of the front panel is the major feature in the flexibility of the console. Each of the six modules which comprise the panel is the same size and independently wired. The electrical connection is made when the module is put in place on the panel. This is done by the use of copper tabs on the module making contact with spring contact fingers on the console. The module is held in place with two nuts and bolts which can be quickly removed and replaced. With the modules thus interchangeable and replaceable without any rewiring and without the use of any tools, the console will not become obsolete.

For routine ADL testing, six typical components can be selected, and others can be substituted to suit individual patient needs. The console as seen in Figures 1 and 2 contains modules which provide for the use of three types of switches, a bell button, light bulb sockets in two positions, and two types of wall plugs.

RELATED EQUIPMENT

As stated earlier, this six-module electrical console is part of a set of ADL simulators. The one-module electrical console is designed to accommodate singly the same modules as the larger electrical console. The need for this more limited console will be less frequent, but it is of value when a patient needs intensive practice in a single funcion or task; when he is distracted by the presence of other tasks; and when arm and hand movements are so poorly controlled that surrounding modules interfere with his performance of a selected task.

The eight-module mechanical console was designed to have the general appearance and adaptability of the electrical consoles. The components are mounted on removable panels on the four sides and top of the console and include a pencil sharpener, locks, doorknob, etc.

SUMMARY

A description has been given of ADL simulators designed to overcome the major disadvantages of commonly used ADL boards. Unique features of the new equipment are commercial appearance, compactness and portability, total safety of electrical components, and flexibility and adaptability which permit realism and variety as well as the replacement of obsolete or inappropriate activities. The equipment can be constructed within an occupational therapy department at moderate cost. Design and construction details are available upon request.

GRANTS FROM U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Public Health Service is now accepting applications from public and private nonprofit agencies eligible to receive grants under the expanded Hill-Burton health facility research program authorized by the newly-enacted Community Health Services and Facilities legislation.

A feature of the 1961 act is an increase from $1,200,000 to $10 million in the annual appropriation ceiling for hospital research activities under the Hill-Burton program. It also authorizes appropriations for grants for constructing experimental or demonstration health facilities and for acquiring experimental and demonstration equipment.

Surgeon General Luther L. Terry noted that the newly-enacted legislation marks a big step forward in the Nation's effort to improve not only patient care but also the efficient design and operation of the health facilities in which such care might best be offered.

Public and private nonprofit institutions and groups, including political subdivisions, universities and hospitals, are eligible to apply for funds. The program is administered by the division of hospital and medical facilities of the Public Health Service.

The Appropriation Act limits grants for experimental and demonstration projects to 66 2/3 per cent of the cost of the experimental or demonstration construction and equipment. Federal participation is limited to those portions of the project which are of an experimental or demonstration nature.

As in the past, nonmatching grants for research and demonstration projects are authorized. Grants for service demonstrations such as area-wide planning of hospital and related health facilities are included in this category.

Applications for all types of projects must be received by March 1, 1962, for review by the Council at its June meeting, by July 1 for review at its October-November meeting, and by November 1 for review at its February-March meeting. Recommendations are made by the Council to the Surgeon General who determines the final action.

Representatives of the Public Health Service are available for consultation. Descriptive material, including application instructions and forms, may be obtained from Dr. Jack C. Haldeman, Chief Division of Hospital and Medical Facilities, Public Health Service, Washington 25, D. C.

*Case History**

ADL FUNCTIONS
Quadraparesis

DOROTHY S. HALL, O.T.R.
GEORGE E. SPENCER, Jr., M.D.

Figure 1

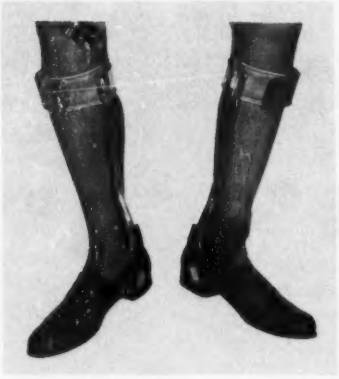

Figure 2

Figure 3

Attending the muscle clinic at the University Hospitals of Cleveland, Ohio, is a forty-seven year old woman with the diagnosis of progressive muscular (or spinal) atrophy of thirteen years duration. The patient was unable to climb stairs, walked with difficulty, and suffered many falls. The patient now has muscular atrophy of the distal portions of both upper extremities, most marked in the hand and tapering off in the midforearm. Pertinent to the activities of daily living (ADL) problem is the fact that she cannot use her hands to perform any real tasks and is terribly incapacitated in this area. In additon, a complete bilateral foot drop is present.

The prognosis for life expectancy should be in the area of ten to fifteen years in view of the subsequent gradual regress over the years. Predominantly peripheral weakness and long course of the atrophy favor this.

BASIC PROBLEMS

After a complete ADL test was recorded and the patient graded in all essential daily activities which have a bearing on the total rehabilitation, it was found that the patient's functional evaluation constituted the following.

The patient is unable to perform any functional activities with the left upper extremity. In the right upper extremity, the patient has a functional right shoulder and elbow, but no dexterity and functionally zero strength of her right wrist and hand for the performance of her daily tasks. With this extremity, she is a able to perform much of her ADL by moving her hand with the help of gravity and the good muscles of the shoulder. Most of her elevation activities are done with difficulty but without assistance.

Evaluation of the lower extremities shows a bilateral foot drop for which she wears braces. She reveals reduced endurance in ambulation and at home needs an attendant with her at least part-time. She does tasks about the apartment with difficulty.

The social service department has arranged for a housekeeper who comes five half-days a week. The Visiting Nurse Association sends a nurse once a week to provide a tub bath.

Her major problems encountered in ADL are the inability to apply braces and put on hose and shoes. If we could facilitate the patient's applying these items, we will have succeeded in assisting this patient in maintaining herself on a more independent level. The wheelchair, which has been provided for weekend use when the patient is alone, could then be eliminated.

*Muscle Clinic, University Hospitals, Cleveland 6, Ohio.

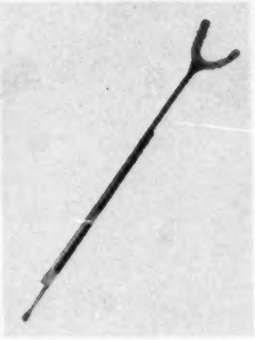

Figure 4

EFFECTIVE RESULTS WITH EQUIPMENT INVOLVED

The main problem the patient encountered in applying her below the knee braces was the inability to buckle the leather straps about her legs. It was necessary to buckle a calf band and outside T-strap. The patient had no pinch or grasp in either hand.

The situation was discussed with the bracemaker, Mr. Arthur Guilford, and it was decided to try Velcro[1] as a fastener for the straps instead of the regular buckles. This has functioned very well and the patient can open and close her straps independently (Fig. 1 & 2).

The patient was too weak to slide her feet successfully into any type of regular shoes including those equipped with rubber shoe laces. Special shoes, shown in the above mentioned illustrations, were made with elastic gores across the top. The shoes are the same weight as the oxfords which they replaced. She is able to use these, for they were designed to come up over the instep as high as possible for support, yet have sufficient stretch so that the foot slides in easily on a slight body weight pressure. They slip on as well as off.

One of the housekeeper's duties before she leaves on Friday is to see that two pair of hose are attached to the four special devices tailored for this patient's individual needs for use over the weekend when alone. Each device was made from a girdle garter sewn to a piece of material the same width as the garter. The piece of heavy cotton strip material is approximately eighteen inches long and turned down to make an eight-inch loop for the patient to swing her hand through. In this manner she is able to use her functional shoulder muscles. She can pull on the hose while on a bed and accomplish the hose process. The over-the-heel problem with tight hose is solved by placing a Velcro band of lint pick-up tape around the right wrist whereby she can rub the hose over the heel (Fig. 3.) The patient uses her teeth to apply the tape to her wrist.

In order to add some diversional pleasure to this patient's spare hours while alone, the successful production of a mouthstick was achieved. A fourteen-inch length of one-quarter inch aluminum tubing was attached to the mouthguard at the outer surface, on the labial aspect of the lower central incisors. This was achieved by the use of quick setting, self-curing Acrylic. The tubing was attached approximately parallel to the horizontal plane of the mouthguard. The patient adapted to the device remarkably well. She was able to remove and insert it herself and found little or no discomfort in keeping it in. She was able to talk with the device in her mouth which we felt was a tremendous advantage (Fig. 4). This was produced by Dr. Maxwell Davis of Cleveland.

Our clinic was very fortunate to have an artist volunteer to work with this patient until she was satisfactorily on her way towards happily working at painting at her own adjusted level.

A new device called "Clean Chew," patented by Dr. Myron Levenson of Cleveland has been introduced to help this patient maintain a maximum level of proper oral hygiene.

SUMMARY

We now have factual evidence from the patient's ADL chart that previous to the successful initiation of the Velcro on her braces, the special shoes and hose devices, this patient was sitting in a wheelchair unless someone was present to assist her. She has now attained maximum personal independence and is enjoying a most interesting life as opposed to her previous status. She is able to maintain her own private apartment and is not being considered for placement in a nursing home.

REFERENCE

1. Listed in the March-April, 1960, American Journal of Occupational Therapy in the "Classified Buyers' Guide."

The University of Nebraska College of Medicine is starting a master's degree program this fall. They are in need of back issues of the *American Journal of Occupational Therapy for* 1948, 1949, 1950 and 1951. They would also like copies of *Occupational Therapy and Rehabilitation.*

If you have copies you no longer need and wish to have some one make use of them, contact H. Dwyer Dundon, O.T.R., Associate Professor, Nebraska Psychiatric Institute, 602 S. 44 Ave., Omaha 5, Nebraska.

Automobile Tire as a Seating Aid for the Pre-School Child*

Figure 1

An inexpensive, relatively short term seating arrangement is frequently needed—something that can be used in the home or outdoors at picnics or the beach. An automobile tire has been found to serve this purpose.

The idea originated somewhere in Europe and was introduced in Chicago by Miss Edna Blumenthal, R.P.T., at a joint occupational therapy-physical therapy meeting in 1960. The tire has since proved of value in a home therapy program.

Figure 2

Figure 3

The patient is placed tailor fashion in the tire with some additional low back and side support provided by a firm foam rubber pillow. The tire gives him the necessary support and stabilization he seems to require to inhibit some of the mass reflex patterns of motion as well as decreasing tension. This allows him to perform gross activities with the upper extremities more effectively.

In these pictures the patient was just beginning to control his trunk movements to progress from trunk flexion to trunk extension to an upright sitting posture and visa versa, at the same time being able to raise his arms beyond 90 degrees. Three months prior to this, this freedom of arm and trunk motion was impossible and still is impossible without this seating aid.

These three pictures show his total range of motion. In Figure 1, he is playing peek-a-boo. In Figure 2, he is catching a ball in his lap, starting from the position of shoulder flexion, then he pushes the ball over the rim of the tire at the same time maintaining his wrists in dorsiflexion, arms adducted and internally rotated, and elbows extended (his dominant pattern of motion was to abduct arms, pushing objects laterally and ending in hypertension). In Figure 3, he is showing that he is "so big."

*Submitted by Sonja Koehler, O.T.R., Illinois Association for the Crippled, Chicago Metropolitan Unit, Chicago, Illinois.

Editorial

STATE OR STATUS

Today medical and allied groups are examining their self and social images and finding much need for improvement. Hence concern is expressed about status—inter-departmental, inter-team and community. No one seems satisfied with their image or status. All hope that others will grant them the position deemed rightly theirs.

Professions have upgraded their educational requirements, concentrated on curriculum content, established higher professional standards and conducted more research. Better medical care for the patients able to obtain such services has resulted, but the raise in status is still lacking and the increased professional training has barred others from entering the fields because they are unable to finance the increased amount of schooling or unable to academically last the tenure of training.

Professions are now understaffed and dependent on sub-professional groups to absorb the increased job burdens. These groups are sometimes untrained, under-trained or departmentally trained but are able to carry the load of specific care needed today in our increased hospital population.

This influx has added more stratification of groups jockeying for status, and so the result is a vicious circle. Increased educational requirements and more advanced degrees are not going to alleviate the problem.

It is hoped the ancillary groups will soon realize status is not something granted a person after the required number of college credits are earned. Nor is one's self or public image changed markedly. College degrees are too common a commodity today to raise respect unless earned.

One's status is dependent upon one's self. If one deserves it, one receives it. Unfortunately those least concerned gain theirs the most easily because their interest is not self-directed but patient oriented. A person concerned with the treatment being given is too enthusiastic to resent interruption of the schedule. Rather he will enlist the person calling for the patient to observe and to calculate the treatment value. The result is an ancillary professional person indoctrinated in the processes of another's techniques. Enthusiasm is contagious.

Faith in one's method gives a stability to a treatment process noted by patient's and co-workers. Apeing others, infringing on other areas are unncessary if one's belief that one's own techniques offer a unique treatment phase. This uniqueness should add to the total treatment process, not be all.

One's contribution canot be an island of self-sufficiency. Time allows only a limited treatment process each day. The patient has twenty-four hours in the day. The contribution of each person he contacts should contribute and substantiate the goals for his recovery. Coordination with others, consideration of others and most of all interest in the aims and hopes of the others on the treatment team will enable one to better plan his own unique contribution at the same time obtain cooperation and consideration from others.

Status can be achieved from others, it is not granted as one's right. Self-engrossment with daily schedules often make others heedless of areas beyond their immediate province. Individual efforts to educate, indoctrinate and coordinate programs are needed to make them aware of all treatment aims and their part in the total program.

It is a normal desire to want regard and esteem from others. It is very difficult to achieve and at times results in a low self-image. Unfortunately self-analysis is usually the last process invoked to change status.

Therefore it is healthy to examine and then resolve to do something about the facets of departmental and inter-departmental relations that are professionally detrimental. An article in this issue entitled "Educational Weaknesses and Occupational Stress" on Page 223 is recommended for your attention. It provides plenty of food for thought for all occupational therapists. Another article entitled "Working with Psychiatric Attendants in Large Hospitals" on Page 242, describes a specific effort to raise the status of attendants in an effort to establish a more effective occupational therapy program. Their results are positive.

Let us hope the self-analyses described in these two articles will help others to realize their individual complaints are common. Let us hope we are given the wisdom to learn and act to overcome them through our own enthusiasm, faith and unselfishness. Each medical ancillary group has evolved from need for better patient care but each contribution is only of value if coordinated into the total patient program. Uniqueness does not mean isolation.

NATIONALLY SPEAKING

NEW OFFICERS

New officers of the American Occupational Therapy Association are:

President: Wilma West, O.T.R.

First vice-president: Ruth Brunyate, O.T.R.

Board of Management members:

Re-elected
Martha Matthews, O.T.R.

Newly elected
George Frye, O.T.R
Elizabeth Collins, O.T.R.

House of Delegates officers:

Re-elected
Vice-speaker: Marjorie Holtom, O.T.R.
Secretary: Margaret Smith, O.T.R.

Representatives to the Board of Management:
Clyde Butz, O.T.R.
Cecelia Sattely, O.T.R.
Louise Tullis, O.T.R.

Chairman of the nominating committee:
Mary Van Gordon, O.T.R.

Eleanor Clarke Slagle Lectureship for 1962:
Naida Ackley, O.T.R.

A complete list of officers is listed on the masthead, Page II.

From the Education Division

It is with pleasure that the education division of AOTA announces the names of those examinees who successfully completed the June 30, 1961, registration examination.

Abendroth, Sara F.
Alkins, Sheila E.
Allen, Mary E.
Anderson, Linda M.
Aponte-Diaz, Consuelo
Barnett, Faith E.
Barton, Sandra R.
Benbow, Mary D.
Benson, Patricia F.
Berg, Orville D.
Beyer, Diane F.
Biggs, Barbara A.
Boness, Wanda T.
Bousquet, Carmen R.
Bowe, Sharon L.
Brockman, Karen J.
Brookhouse, Barbara K.
Brooten, Nancy J.
Budar, Emily K.
*Buehl, Mary L.
Burnside, Margaret S.
Burwitz, Betty L.
Bystol, Helen M.
Bystol, Joan L.
Caldwell, Charlene B.
Caraway, Edward E.
Carey, Catherine
Carlson, Sally K.
Carpenter, Carolyn M.
Cassell, Susan M.
Caviness, Esther H.
Christian, Margaret L.
Coffey, Carol J.
Colon-Nebot, Rolando
Colty, Alber J.
Conroy, Mary D.
Corso, Ernest A.
Crandall, Lois A.
Crockett, Barbara A.
Cronin, Anne T.
Cross, Marsha L.
Curish, Judith S.
Dainow, Keren J.
Davis, Linda J.
Dean, Marlene K.
DeLoatch, Eleanor M.
Devore, Janis M.
Dougherty, Laura T.
Dresser, Sandra J.
Eckrich, Sharon K.
Ehrensperger, Barbara H.
Eisig, Claudia A.
*Emigh, Margaret H.
Fagg, Donna B.
Ferguson, Gail C.
Ferguson, Margay
Figueroa-Ruiz, Natalio
French, Arlene M.
Freshman, Katherine C.
Funasaki, Joanne T.
Gardner, E. Ann
Garens, Jan
Garfield, Mary M.
Gehl, Patricia M.
Goldmuntz, Arlette
Gooderham, Edith A.
Gregory, Judith T.
Guillette, Stella M.
Haggenmiller, Marian L.
Handler, Jacqueline
Hanson, Judith K.
Harding, Eugenia H.
Harris, Pauline M.
Harvey, Elinor G.
*Hasselkus, Betty R.
Haynes, Mary J.
*Hendrickson, Janet K.
Hershe, Barbara L.
Hill, Dorothy N.
Hitchcock, Maryann E.
Hoffman, Anne
Hohman, Carol A.
Holtz, Jeanne A.
Jansen, Joann J.
Johnson, Karen G.
Johnson, Laura P.
Jones, Patricia H.
Jordan, Ruth I.
Jorgensen, Betty A.
Keitt, Ruth M.
Kidd, Jerelyn J.
Kimball, Paul H.
Knannlein, Wanda A.
Knight, Mary A.
LaGrone, Janice L.
Larrick, Nancy A.
LeClaire, Lois S.
Lee, Muriel B.
Levowich, Judith
Lind, Judith A.
Linnerson, Marilyn C.
Luyanda, Alma N.
McCrea, Peggy M.
McGuire, Sharon E.
McKinley, Milbrey E.
Macauley, Kathleen B.
MacDonald, M. Sandra
Maledy, Betty K.
Mansur, Gail T.
Marshall, Sharon S.
Mastro, Carol E.
Matson, Carol E.
Mellen, Carol A.
Miller, Annette M.
Miller, John D.
Moench, Monette E.
Mukamal, Violet
Narahara, Mildred M.
Naylor, Joan E.
Ocker, Patricia A.
Owen, Mary A.
Oza, Ramesh K.
Parker, Carolyn M.
Pascoe, Elizabeth A.
Perry, Joan F.
Purdy, Martha E.
Quinn, Sheila M.
Raitz, Marion C.
Read, Joyce A.
Richter, Barbara D.
Riekena, John B.
Robinson, Nayda J.
Rodriguez-Mateo, Edna S.
Rood, Donna E.
Rosen, Lauretta A.
Ross, Charlene M.
Rudy, Margaret H.
Ruiz de Valcarcel, Rosalina
Sanchez-Perez, Carmen D.
Sargent, Bette S.
Schalker, Marian L.
Schettler, Lynne H.
Schlomer, Kaye J.
Schneider, Ruth M.
Schubert, LeRoy C.
Schulz, Maymie J.
Schweitzer, Nancy J.
Scott, Linda J.
Shah, Nalini M.
Sharpe, Barbara J.
Shinners, Roberta R.
Shoemyen, Margaret W.
Siebert, Carol A.
Siscoe, Margaret E.
Smith, Charlotte E.
Smith, Linda K.
Sorenson, Ruth
Stein, Susan E.
*Stephens, Ruby C.
Stibitz, Martha A.
Stone, Estella
Suggs, Eleanor
Surette, Bonnie E.
Swanty, Mary E.
Taylor, Rebecca L.
Thode, Mary V.
Thome, Frances A.
Thompson, Judith L.
Thompson, Kathryn W.
Thompson, Lorna C.
Timms, Judith D.
Tompkins, Nora A.
Tucker, Margaret B.
Turnbull, Patricia S.
Vincent, Beverly H.
Wagner, Charlotte E.
Wagner, Marilyn S.
Ward, Lucy G.
Warsaw, Irene E.
Wasserman, Judith
Weatherby, C. Ann
Wechter, Elizabeth
Weintrob, Joan J.
Weisberg, Mary W.
Welleford, Robert E.
Wendt, Louise R.
Westgaard, Carolyn A.
White, Russell M., Jr.
Wigren, Gayle F.

Wildin, Cecile S.
Wiley, Carol H.
Williams, Agnes E.
Williams, Karen A.
Wong, Miriam F.
Yonekawa, Setsu
Zabors, Barbara B.

*Completed with honors.

GRADUATE STUDY GRANTS

The American Occupational Therapy Association's committee on graduate study administered the $33,400 grant offered by the Office of Vocational Rehabilitation for graduate study related to occupational therapy. A selection subcommittee of the committee on graduate study awarded the following traineeships.

Catherine Bingaman, O.T.R., master's degree level, amount $2,400 for the academic year 1961-62, at Teacher's College, Columbia University, New York City, in guidance and counseling.

After completing her bachelor's degree in education at Tufts University, Miss Bingaman received her certificate in occupational therapy from Boston School of Occupational Therapy.

At present she is chief occupational therapist at the Hospital Center at Orange, New Jersey. After completion of her studies Miss Bingaman hopes to teach occupational therapy.

Jean M. Fleming, O.T.R., master's degree level, amount $2,400 for the academic year 1961-1962, at the University of Florida, Gainesville, Florida, in guidance and counseling.

Mrs. Fleming received a certificate in occupational therapy from the Philadelphia School of Occupational Therapy. She holds a bachelor's degree in education from the University of Missouri, Columbia, Missouri. Mrs. Fleming's graduate program will prepare her for work with emotionally disturbed children which eventually will be in the area of special education.

Renate L. Gerstman, O.T.R., master's degree level, amount $2,400 for the academic year 1961-62, at Washington University, St. Louis, Missouri, in psychology.

An alumni of the St. Louis School of Occupational Therapy, Washington University, St. Louis, Missouri, with an A.B. in psychology, Mrs. Gerstman had experience with the Army and War Department, the Elgin State Hospital and the Indiana Society for Crippled Children and Adults

She hopes to use her education in an administrative capacity or teaching occupational therapy.

Martha Winter Goll, O.T.R., master's degree level, amount $2,400 for the academic year 1961-62, at the University of Nebraska, Nebraska Psychiatric Institute, Omaha, Nebraska, in psychiatric occupational therapy.

Mrs. Goll holds a bachelor of science degree in occupational therapy from Washington University in St. Louis, Missouri. She has been activity program supervisor at Manteno State Hospital, Manteno, Illinois, and plans to return to Illinois to continue working in the field of psychiatry.

Marjorie B. Herring, O.T.R., master's degree level, amount $2,400 for the academic year 1961-62, at Rollins College, Winter Park, Florida, in business administration.

Originally a science major, Mrs. Herring received a diploma in occupational therapy from Milwaukee-Downer College. She has also had additional work at the University of Wisconsin-Milwaukee in psychology. She has done experimental studies in the area of physical disabilities in motivation of the patient through measurement of performance and in grading specific programs for increasing neuromuscular response.

Preparation for an administrative position to promote occupational therapy is her goal.

Catherine Hoffman, O.T.R., a continuation grant for studies at the University of Connecticut, Storrs, Connecticut.

Miss Hoffman completed her studies for her master of science degree in education at the end of the summer session, 1961, in the area of homemaking for the disabled.

Marjorie Holtom, O.T.R., first year doctoral level, amount $2,800 for the academic year 1961-62, at the University of Michigan, Ann Arbor, Michigan, in guidance and counseling.

A graduate with a bachelor's degree in occupational therapy of Western Michigan University, Miss Holtom received her master's degree in guidance and counseling from the University of Michigan. Her doctoral program will prepare her for an administrative position either in the clinical or educational area, and her experience at the Great Lakes Naval Training Base and at Eastern Michigan University has given her the background for this advanced study.

Christina C. Kimball, O.T.R., master's degree level, amount $2,400 for the academic year 1961-62, at Berry College, Miami, Florida, in guidance and counseling.

A bachelor's degree in art from Woman's College of the University of North Carolina, and a certificate in occupational therapy from the Richmond Professional Institute prepared Mrs. Kimball for her advanced study.

Her interest centers around work and research techniques with the exceptional child in the Florida public school system. She has been employed by them and has been given a leave of absence to complete her graduate work.

Mrs. Sol Llado-Hernandez, O.T.R., master's degree level, amount $2,400 for the academic year 1961-62, at New York University, School of Education, in occupational therapy.

Mrs. Llado received her bachelor's degree in occupational therapy from New York University and a certificate in physical therapy at the University of Puerto Rico. She hopes to return to teaching in Latin America after she completes her advanced study.

Marilyn Matheis, O.T.R., master's degree level, amount $2,400 for the academic year 1961-62, at the University of Southern California in occupational therapy.

Miss Matheis was graduated from Mt. St. Vincent, Riverdale, New York, with a bachelor of science in English and continued her work for a certificate in occupational therapy at the University of Southern California. Since that time she has had clinical experience with the California Elks' major project (C.P. homebound) in the Mojave Desert and has studied psychology at the University of Hawaii while working in geriatrics and with brain damaged children. She plans to specialize in psychiatric occupational therapy.

Erma H. Meade, O.T.R., master's degree level, amount $2,400 for the academic year 1961-62, at the University of Southern California, Los Angeles.

Mrs. Meade has graduated with a bachelor's degree in applied arts from the University of Cincinnati, and received a certificate in occupational therapy at the University of Southern California. She has an interesting employment history including foreign service with the American Red Cross and as an occupational therapist at the Brentwood Veterans Administration Hospital, West Los Angeles, California. She is a member of the Delta Phi Delta art honor society.

She plans to teach occupational therapy after completion of her course of study.

Margaret Nelson, O.T.R., master's degree level, amount $2,400 for the academic year 1961-62, at San Jose State College, San Jose, California, in occupational therapy.

After receiving her bachelor of science degree in occupational therapy from Ohio State University, Columbus, Ohio, Miss Nelson has been employed as the supervisor of occupational therapy at the Children's Hospital in Columbus and director of occupational therapy at Elyria Memorial Hospital, Elyria, Ohio, where she started the occupational therapy department. She indicates her advanced study will enable her to become a more effective administrator of an occupational therapy department.

Ione Olson, O.T.R., master's degree level, amount $2,400 for the academic year beginning February, 1962, at the University of Nebraska, Nebraska Psychiatric Institute in psychiatric occupational therapy.

Mrs. Olson received a diploma in occupational therapy from Milwaukee-Downer College, Milwaukee, Wisconsin, and a bachelor of science degree in occupational therapy from the University of North Dakota. After some clinical experience with the Veterans Administration she returned to the University of North Dakota as an assistant professor and has been teaching in the school of occupational therapy there.

After her leave of absence she plans to return to teaching at the University of North Dakota.

Diane Peters, O.T.R., a continuation grant for studies at the University of Southern California, Los Angeles, California, in the amount of $1,200.

Miss Peters will complete her studies and research projects in early 1962. Studies will include university teaching and research.

Ruth Smiley, O.T.R., master's degree level, amount $2,400 for the academic year 1961-62, at the University of Nebraska, Nebraska Psychiatric Institute, in psychiatric occupational therapy.

Miss Smiley's professional education was completed at Columbia University after being graduated with a bachelor's degree in history from Wells College, Aurora, New York. She also holds a master's degree in guidance and student personnel administration from Teacher's College, Columbia University, New York City.

She was director of the women's occupational therapy departments at New York Hospital, Westchester Division, White Plains, New York. She plans to teach psychiatric occupational therapy.

The Third International Congress of THE WORLD FEDERATION OF OCCUPATIONAL THERAPISTS

October 22-26, 1962

Philadelphia, Pennsylvania

The third international congress of the World Federation of Occupational Therapists will be held in Philadelphia, Pennsylvania, U.S.A., October 22 to 26, 1962. The Bellevue-Stratford Hotel will be the headquarters for the Congress; rooms will also be available at the Hotel Sylvania and the John Bartram Hotel directly across the street.

The theme of the congress will be "Cultural Patterns Affecting Rehabilitation." All proceedings will be held in the English language. On Monday, October 22, there will be special field trips to occupational therapy departments in the area which will also permit sightseeing en route. The congress will formaly open at 10:00 A.M., Tuesday, October 23, 1962, following a continental breakfast. Subjects to be discussed are: "How Customs in Different Countries Modify the Application of Ocupational Therapy"; "Recent Developments in Occupational Therapy"; "Vocational Assessment and Resettlement (Pre-Vocational Evaluation and Placement)"; "Summaries of Research Projects or Special Studies"; "Student Adjustment to Foreign Education." The congress will formally close with a banquet on Thursday evening at which Dr. Howard A. Rusk will be the speaker. On Friday, October 26, there will be field trips to hospitals and rehabilitation centers in Philadelphia.

Each member association will be asked to base its scientific exhibit on the theme of the congress. Plans are also being made for study courses directly following the congress in New York City or vicinity and Toronto, Canada. The dates of these will be October 28 to November 1, 1962. There will be six study courses as follows: "The Treatment of Industrial Accident Cases," Toronto, Canada, "Vocational Assessment and Resettlement," "Special Devices for the Handicapped," "Neuromuscular Facilitation," "Psychiatry," and "The Severely Disabled." The fee for each of these courses will be $20.00. It is also planned to have a two-day discussion group on "The Education of Occupational Therapists," either directly before or after the congress, providing enough school personnel can be present. This will be held in Philadelphia.

The Council of the World Federation of Occupational Therapists will meet in Philadelphia, Monday, October 15 to 18, at the Philadelphia School of Occupational Therapy. Special arrangements for housing will be made for Council delegates for that period.

The dates of the congress and study courses have been planned to permit registrants from Europe to take advantage of the 17-day excursion rates which naturally cut the cost of air fare. The registration fee for the congress is $15.00 for those registering by June 1, 1962, after that date $18.00. This does not include the banquet or field trips.

For this congress to be a success it will need the cooperation of all occupational therapists. In the preliminary program there will be a request for papers and summaries of research projects. Even if it is impossible for the individual therapist or those in related fields to be present, the paper may be included and read by a colleague. All papers must be in English and all the proceedings of the congress will be held in English.

Preliminary programs will be mailed to all member associations in November, 1961. If you do not receive one by March, 1962, write to the secretary of your association.

CLINICAL AFFILIATION

To assist in alleviating the shortage of occupational therapists, the United States Army Medical Specialist Corps offers a thirty-six week occupational therapy clinical affiliation program. This program meets the requirements of the council on medical education and hospitals of the American Medical Association and the American Occupational Therapy Association.

The Army student occupational therapy program is established to assist students in becoming graduate occupational therapists and to qualify them to serve in the Army Medical Specialist Corps. This educational program provides substantial financial assistance to occupational therapy students during the last twelve to twenty-four months of college. Participants receive monthly pay and allowances of more than $200. The payment of tuition and other fees remains the responsibility of the student.

Students who have achieved outstanding academic records, and upon recommendation of the faculty, may be selected for participation on the Army occupational therapy student program and be enlisted in the Women's Army Corps, Army Reserve, for the purpose of completing the requirements for a baccalaureate degree. Advanced standing students may be enlisted for the purpose of completing the educational requirements of a curriculum in occupational therapy. Selection of applicants is based upon personal and scholastic qualifications.

After graduation, or the completion of all academic requirements for a baccalaureate degree, participants will be separated from the Women's Army Corps Reserve and commissioned as second lieutenants in the Army Medical Specialist Corps and participate in the Army occupational therapy clinical affiliation program.

Application forms may be obtained from the Army Medical Specialist Corps procurement counselor in your Army headquarters or by writing the office of the Army Surgeon General, Attn.: MEDPT-MP, Washington 25, D. C.

In Memoriam

Mrs. Gladys W. Dawes
319 N. High St.,
West Chester, Pa.
Deceased, Nov., 1960.

Mrs. Marilyn Nelson
503 N. Wolfe St.,
Baltimore, Md.
Deceased, June, 1961.

Mr. Aureo Laguer-Calderon
cc No. 6 Urbanizacion Campo Rico
Rio Piedras, P.R.
Deceased, May, 1960.

Mr. Paul Evans
4819 15th N.
Arlington 5, Va.
Deceased, Dec., 1960.

Sister M. Clarice (Stanco) O.S.B.
St. Scholastics Priory
Duluth, Minnesota
Deceased, September 27, 1961.

Miss Hazel A. Stevens
State Hospital
Kalamazoo, Michigan
Deceased, November 1, 1961.

DELEGATES DIVISION

DISTRICT OF COLUMBIA

Delegate-Reporter, Renee Achter, O.T.R.

Members of the District of Columbia Occupational Therapy Association had the opportunity to attend and participate in a number of international, national and local meetings of exceptional interest, which were held in Washington during the past year.

The third international Congress of Physical Medicine convened here in August. Mention of occupational therapy was made in a number of papers presented.

Occupational therapists participated both as appointed members of committees and as delegates to the White House Conference on Aging.

A meeting held at the National Academy of Science, which explored prosthetic research and development, was also well attended by occupational therapists.

An institute for occupational therapists interested in improving their supervisory and administrative skills was sponsored by the American Hospital Association and held here in May. Sixty-four therapists from nineteen states as well as Canada attended. Visits to occupational therapy clinics in this area climaxed a stimulating four days of talks and workshops.

Washington was host to the annual tri-state meeting of the Virginia, Maryland and District of Columbia Occupational Therapy Associations. The theme selected for this meeting was "Research." Dr. Lee Gurel discussed "Procedures in Clinical Research," Helen Christrup, M.A., O.T.R., reviewed "Research in Psychiatry" and Eugene Levine, Ph.D., presented "Practical Projects in Research."

Sixty active and eight associate members made up the District of Columbia Occupational Therapy Association this year. Meetings were held monthly between September and May and speakers were heard on such diverse topics as "The Psychological Management of the Multiple Sclerotic Patient," "The Occupational Therapists Role in Disaster," "Fundamentals of Speech Therapy" and "Research Projects With Regressed Schizophrenic Patients." Two meetings were devoted to association business and at one meeting Miss Wilma West discussed the scope of the curriculum study now in progress.

The committee on education and special studies further arranged a lecture and demonstration on upper extremity splinting, a talk on civil defense and a joint course with the Physical Therapy Association entitled "Principles of Neurophysiology."

As can be seen from the above it was a busy year for our members.

Also hard at work during the past year was the recruitment committee, planning and preparing for an intensive recruitment campaign using mass media which will get under way later this month.

OFFICERS

President ..... Marjorie Conway, O.T.R.
Vice-President ..... Capt. Arvilla Dyer, O.T.R.
Secretary ..... Barbara Itoman, O.T.R.
Treasurer ..... Lt. Peter Couchman, O.T.R.
Delegate ..... Renee Achter, O.T.R.
Alternate Delegate ..... Rena Graham, O.T.R.

OHIO

Delegate-Reporter, Wilma K. Morrow, O.T.R.

Following an extensive survey of the structural weaknesses and strengths of our association, this has been a year of building on what, we anticipate, will be a much firmer foundation for the future.

Considerable headway has been made in the matter of better communications through newsletters, copies of the annual reports and Board of Management minutes for the membership, and a close liaison between the district organizations and the state association.

An intensive total study has been completed regarding the position of the recent occupational therapy graduate and his position in the professional community with a view toward making these individuals feel wanted, needed and included. Findings from this study were reported at the annual business meeting with resulting association approval for implementing new procedures in encouraging creative, contributing and interested new graduates. This will be one of the most important aspects of OOTA's expanded programing plans.

A statement of need for upgrading sub-professional occupational therapy workers (non-psychiatric) in Ohio was presented to OOTA by the rehabilitation consultant of the Ohio Tuberculosis and Health Association. As a result, with membership approval, the special studies committee, Anne Allen, O.T.R., chairman, and a sub-group composed of a representative of each of the five districts conducted a week's institute in occupational therapy for the older patient as a cooperative attempt to encourage and assist the non-registered occupational therapy workers. Fourteen persons of varied backgrounds and experience completed the course. During the institute the trainees seemed to become more aware and interested in the problems of the patients as well as their own relationships and effectiveness with the patients and hospital staff. There seemed to be a diminishing concern over ordering supplies, finding craft ideas, etc.

Following the institute the Ohio Department of Health saw fit to adopt a proposal made by Elizabeth Laschinger, rehabilitation consultant of the Ohio Tuberculosis and Health Association, for the inauguration of a program to introduce and/or extend occupational therapy in nursing homes and chronic illness facilities. The proposal was supported by the Ohio Occupational Therapy Association. Miss Theresa M. McCoy, O.T.R., has been employed by the Department of Health Nursing Home Unit, Division of Chronic Diseases, to guide and direct this program. We feel that we are beginning to work on raising professional standards for occupational therapy in Ohio.

The theme of our annual conference held in Akron was "Setting Our Sights in the Sixties." Subjects for discussion were "New Trends in Psychiatric Services," "White House Conference on the Aging," "Utilizing Aides and Volunteers" and "Research on Job Sampling and Work Evaluation."

Midyear meetings of the American Occupational Therapy Association were also held in Akron. Some planned overlap of meeting schedules afforded an opportunity for both groups to attend various sessions.

Immediately following the OOTA conference, Mrs. Mary Alice Coombs, AOTA field consultant in psychiatric rehabilitation, conducted the first area seminar for all Ohio, West Virginia and Western Pennsylvania therapists. About 50 persons were in attendance.

OFFICERS

President ..... Margaret K. Mathiott, O.T.R.
Vice-President ..... Shirley Lewis, O.T.R.
Secretary ..... Marguerite M. Klein, O.T.R.
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Delegate ..... Wilma K. Morrow, O.T.R.
Alternate Delegate ..... Nancy Vesper, O.T.R.

TEXAS

Delegate-Reporter, Hope Keeney, O.T.R.

During the past year many of the efforts and activities of the Texas Occupational Therapy Association have been directed toward broadening our concept of present-day rehabilitation; defining our role in this concept for our own guidance, as well as that of our administrators, medical directors, and colleagues in related professions; and increasing public knowledge concerning occupational therapy, particularly in regard to recruiting and financing students.

In September, 1960, our association, with the Texas Medical Association and the Texas Hospital Association as co-sponsors, held a two-day institute in Austin on "Changing Concepts in Hospital Rehabilitation." This was made possible by a grant from the H. E. Butt Foundation, with added assistance from Hoffman-LaRoche Laboratories. Physicians, administrators and persons from varied para-medical fields participated in stimulating discussions following excellent presentations by nationally known speakers.

During November, Jo Shelton represented us at a meeting of the special professional relations conference of the Texas Hospital Association held in Austin. She is now a member of their state committee. In January, 1961, she also represented us at the 28th annual conference of the Texas Association for Mental Health, in Galveston, as a member of the Mental Health Careers Committee.

We co-sponsored, with the United Cerebral Palsy Association of Texas and the Texas Medical Association, a symposium on cerebral palsy at Galveston in April. Dorothy Sniffin participated in the program and others attended the meeting.

During August we participated in the meeting of the Texas Rehabilitation Association held in Houston. Here the effective use of community agencies in the rehabilitative process was stressed. Also in August was the seminar in Dallas conducted by Mary Alice Coombs and attended by therapists from Arkansas, Oklahoma and Texas who were interested in psychiatry.

In addition to participation in career days at local schools over the state and other person-to-person contacts, we have found that a more thorough acquainting of high school counselors with our profession has proven a very effective and far-reaching recruitment tool. With the assistance of the Tuberculosis Associations in Houston and Dallas and interested individuals, a complimentary meal was served. This was followed by the showing of one of the available descriptive films and a tour of several OT clinics. Houston will repeat this in October.

At long last, through the arduous efforts of Dorothy Denn, we have completed our "Tell-A-Story" portable exhibit, with a series of slides which are readily interchangeable. It has already proven its worth, and we are presently building up our file of slides.

Our annual meeting, held in Houston May 12-13, with the general theme of "Chart Your Course," featured such topics as "The ABC's of PNF," "Spine Instrumentation for the Management of Scoliosis," "Legal Aspects of Medicine," and "A Fiberglass Positioning Device for the Severely Burned Hand." This last discussion, presented by Lt. Mary Yeakel of Brooke Army Medical Center, was supplemented by an excellent exhibit which showed the steps in making the device.

The Southeast District continues its work on that section of the development advisory committee concerned with the officers of the American Occupational Therapy Association.

OFFICERS

President ..... Louise McMillen, O.T.R.
Vice-President ..... Alice Curd, O.T.R.
Secretary ..... Jean Dillon, O.T.R.
Treasurer ..... Melva Jo Shelton, O.T.R.
Delegate ..... Hope Keeney, O.T.R.
Alternate Delegate ..... Lucile Lacy, O.T.R.
Public Relations Coordinator ..... Clifta Winans, O.T.R.

WISCONSIN

Delegate-Reporter, Marilyn Hennessy, O.T.R.

The Wisconsin Occupational Therapy Association has had two full and interesting years. Membership now totals 114. Monthly meetings have been held from October through June with the programs of special interest.

Two sessions on group dynamics were presented by Mrs. Faye Soffen of the University of Wisconsin-Milwaukee. Therapists were enthusiasstic about her presentation and seven enrolled in the university's group dynamics course. Programs on patient-therapist relationships discussed by Dr. Berlin, communications discussed by Dr. Schuette and sexual deviations discussed by Dr. Benjamin were well attended. At several meetings role playing was utilized successfully to demonstrate more effective communication between therapists, students and patients.

Program highlight was in January when 91 therapists gathered to learn the developments of occupational therapy during the past ten years. A special effort was made to encourage non-working therapist to attend and the results were gratifying. As an outgrowth of this meeting, a geriatric seminar was presented for non-working registered therapists who were interested in returning to work. Fifteen therapists attended six sessions covering medical aspects, theory of occupational therapy, activities of daily living, practical aspects, and nursing home tours.

Especially active has been the education committee. Mrs. Marion Hartman, O.T.R., has completed arrangements which makes it possible for occupational therapists to receive a master's degree in education. Graduate work is now available at the University of Wisconsin-Milwaukee in psychology, social work, and education. Another project was the presentation of six sessions on statistics presented by Dr. Harry Madison, UW-M.

The Wisconsin Occupational Therapy Association looks forward to the coming year with plans for more active participation and increased recruitment efforts.

OFFICERS

President ..... JoAnne McCormick, O.T.R.
Vice-President ..... Anita Wolfe, O.T.R.
Secretary ..... Shirley Zurchauer, O.T.R.
Treasurer ..... Bettilou Purrman, O.T.R.
Delegate ..... Marilyn Hennessy, O.T.R.
Alternate Delegate ..... Barbara Weaver, O.T.R.

Weaknesses and Stress . . .

(*Continued from Page* 241)

5. The Massachusetts Department of Mental Health "Capacity Sheet," November 1, 1957.
6. Ibid., p. 172.
7. Ibid., p. 172.
8. Ibid., p. 173 ff.
9. Lefton, Mark, et al. "Status Perceptions of Psychiatric Social Workers and Their Implications for Work Satisfactions." Presented at the February, 1960, annual meeting of the American Orthopsychiatric Association.
10. Ibid., pp. 2-3.
11. Ibid., p. 4-6.
12. Ibid., 6-8.
13. Ibid., p. 8-9.
14. Greenblatt, Milton, Daniel J. Levinson and Richard H. Williams. *The Patient and the Mental Hospital.* Glencoe, Illinois: The Free Press, 1957, p. 5.
15. Ibid., p. 17.
16. Ibid., pp. 6-7.

ACKNOWLEDGMENT

The authors of the present study wish to express their appreciation to Dr. Milton Greenblatt, assistant superintendent and director of research and laboratories of the Massachusetts Mental Health Center, whose efforts were most instrumental in bringing this article to fruition.

REVIEWS

ACTION FOR MENTAL HEALTH. Basic Books, 1961.

In 1955 Congress authorized a study to "analyze and evaluate the needs and resources of the mentally ill in the United States and make recommendations for a mental health program." This study has been carried out by the Joint Commission on Mental Illness and Health, a multi-disciplinary group representing thirty-six agencies concerned with health and welfare. *Action for Mental Health* is the final report of the Joint Commission's study and is probably the most impressive document on the problem of mental illness in this country that has ever been written. It is the first time an attempt has been made to delineate the total problems involved in providing services for mental patients and to make minimum standards of adequate care financially possible for any person who needs such services in the United States.

The arrangement of the book enhances its effctiveness. The "Summary of Recommendations" occurs at the beginning and is followed by an explanation of the purpose and philosophy of the report. Then comes the detailed report. Some of the body of the report is expansion and validation of recommendations in the summary and would hopefully be effective in convincing influential but medically "lay" readers. Other sections give the Commission's theory of why past efforts to help the mentally ill have been so limited and so unsuccessful.

Complete as book is, it is not burdensome to read, thanks largely to the vitality of its outlook and the directness of its style. The Commission has not allowed its approach to the problems of mental illness to be inhibited by convention or precedent in concepts or practice, rather there has been courage in disregarding traditional values and solutions. Readers who are familiar with the situations and problems encountered in working with the emotionally disturbed will find the honesty of viewpoint refreshing, the objectivity and thoroughness of the background study reassuring and the recommendations logical and convincing. At only one point does this excellent standard seem to falter. In the section on future psychiactric facilities recommended for more than short term hospitalization, the report quotes "The large mental hospital is antiquated, outmoded, and rapidly becoming obsolete. We can still build them but we cannot staff them; and therefore we cannot make true hospitals of them . . . I do not see how any reasonably objective view of our mental hospitals today can fail to conclude that they are bankrupt beyond remedy. I believe therefore that our large mental hospitals should be liquidated as rapidly as can be done in an orderly and progressive fashion." Yet for the care of chronic mental patients the Commission recommends that existing state hospitals of over 1000 beds be eventually "converted into centers for the long-term and combined care of chronic diseases, including mental illness," which will hopefully provide better care than the present state hospital but at a saving in cost and personnel compared to intensive treatment centers of 1000 beds or less.

Only one Commission member, Miss Loula Dunn, dissented on the basis that the Commission on Chronic Illness after a seven-year study does not favor independent chronic-disease hospitals and feels services for these patints should be part of general hospital services, and that the Joint Commissions proposal for use the large state hospitals is a solution but it is not a good one. This recommendation does not sound like "liquidation," but rather like perpetuation. While recommendation to liquidation might bc unpopular due to the tremendous past investment of state monies in these large institutions, the Joint Commission has had the courage to recommend major spending of tax funds to provide adequate care and even has recommended changes in tax structure to raise the necessary funds and therefore cannot be suspected of advocating this solution from expediency. If this solution is followed, however, will there eventually be another Commisison to investigate and make recommendations to improve the condition of patients of whatever diagnoses who have been labeled chronic and assigned to the mammoth institutions restricted to their care?

The total report is sufficiently interesting to merit at least one careful reading, not skimming, by every occupational therapist. Those working in the psychiatric area, or involved with the education of occupational therapy students in academic or clinical setting should have a copy of the report for re--reading and Study. If the Commission is correct that Federal Government must actively participate in solving the problem of providing adequate services for the mentally ill for all its citizens (and the report seems convincing on this point) and if the Congress of the United States pays heed to the recommendations of the Commission which is established to seek the solution, then the recommendations of the Joint Commission are truly a blueprint for the psychiatric services of the future and a blueprint for medical personnel of all disciplines sharing this work.

—Naida Ackley, O.T.R.

COMEBACK. Comeback, Inc., 16 West 46 Street, New York 36, N. Y.

"Comeback" tells a moving story of how Johnny, a small boy confined to a wheelchair, learns to live again through the help of a trained and understanding recreation specialist. Filmed on location in four New York hospitals, the camera finds Johnny withdrawn into a

world of silence and follows him through a series of hospital activities. The story focuses on the psychological and social aspects of the total rehabilitation process.

The film is sponsored by Comeback, Inc., a new organization which claims to be the only national health agency dealing solely with therapeutic recreation for the aged, the ill and the handicapped. Dr. Howard A. Rusk is chairman of the advisory board for Comeback, Inc., Mrs. Beatrice H. Hill is president of the organization, and Roy Campanella is head of the honorary national committee.

Producer of the film was Jack Heim, formerly of the NBC-TV *Dave Garroway Show.* The story moves slowly at times, but has dramatic impact and should be of interest to volunteer groups. The film has some excellent scenes of hospital activities. It may be useful in the orientation of occupational therapy students to hospital recreation. The 16mm film is in full color and is available on loan through Comeback, Inc.

RECREATION ACTIVITIES FOR THE HANDICAPPED. Frederick M. Chapman. New York: The Ronald Press Company, 1960, 309 pp.

Written especially for those working with groups of the handicapped, it suggests how recreation can be a valuable adjunct to treatment and gives ideas on leadership techniques. The author describes briefly many varied activities, giving directions, necessary equipment and a listing of the disability areas where the activity might be useful.

The book has an index arranged by disability areas and four appendices: one on how to discover interest through the use of a checklist, a calendar of holidays, references, and addresses of sources of assistance.

—Jane Trout, O.T.R.

AN INVESTIGATION INTO LIFE'S SATISFACTIONS OF GERIATRIC MEN AND WOMEN LIVING IN PROTECTIVE ENVIRONMENTS. Alberta D. Walker. Unpublished master's thesis, department of occupational therapy, University of Southern California, 1959. Available through interlibrary loan.

A proposed questionnaire, under development to measure the amount and kind of satisfaction being derived from life in the areas of sustaining, social relations, achievement, enhancing, and inspirational needs of aged individuals, was subjected to an item analysis based on the internal criterion of the total test scores. The computations representing the internal validity of each of 156 items were presented. Seventy per cent of the items were significant at or above the .10 level.

—A. Jean Ayres, O.T.R.

A STUDY OF LIFE'S SATISFACTION OF THE AGED IN PROTECTIVE ENVIRONMENTS. Teresa M. McCoy. Unpublished master's thesis, department of occupational therapy, University of Southern California, 1959. Available through interlibrary loan.

The Life's Satisfaction Questionnaire developed by the author and Alberta D. Walker was administered in the original form and statistically analyzed in both its original form and a revision based on Walker's item analysis. The revised form, which deleted items with the least agreement with the internal criterion of total test score, increased the range of test scores and slightly increased the agreement of the test scores with external criteria. Significant associations were found between questionnaire scores and self-ratings, between life's satisfaction as measured by the questionnaire and the environment in which the respondent resided, and between satisfaction and the presence of hobbies. Miss McCoy was a fellow of the National Foundation.

—A. Jean Ayres, O.T.R.

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum ad $4.00 *for* 3 *lines, each additional line* $1.00. (*Average* 56 *spaces per line.*) *Classified display, boxed,* $5.00 *per column inch. Copy deadline first of each month previous to publication.*

POSITIONS AVAILABLE

Help wanted female: OTR to head department in large private psychiatric hospital, 35 miles from New York City. Attractive salary. 5 day week. 4 weeks vacation. 7 holidays. Many fringe benefits. Write Box 15, American Journal of Occupational Therapy, 3514 N. Oakland Ave., Milwaukee 11, Wis.

Opportunity to organize complete activity program in newly constructed geriatric nursing service located near Indianapolis. Salary commensurate with experience. Many personal benefits. Contact Robert F. Oedham, Superintendent, Marion County Home, R.R. 10, Box 333, Indianapolis 19, Indiana.

Staff position for registered occupational therapist or eligible graduate, rehabilitation dept. of large, modern tuberculosis hospital. Pleasant suburban location with good transportation, shopping and recreational facilities. 40 hour week, paid vacation and holidays, liberal cumulative sick leave, retirement plan. Full maintenance available at reasonable rate. Opportunities for further education in local universities. Write: Director of Rehabilitation, Sunny Acres Hospital, Cleveland 22, Ohio.

OCCUPATIONAL THERAPISTS for California's progressive programs in state mental hospitals and for physically handicapped children in special schools. Opportunities for imaginative and resourceful therapeutic activities. Eligibility for registration with the national registry of the American Occupational Therapy Association is required. No experience is needed to start at $436 a month. Positions in schools under the Crippled Children Services program are open also to experienced occupational therapists at $481 a month. Attractive employee benefits. Secure details from State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

REGISTERED OCCUPATIONAL THERAPIST. Permanent full time position available for staff therapist interested in varied and creative program in a general New York City hospital. Please send resume to: Mrs. M. Morgenstern, Personnel Department, Beth Israel Hospital, 10 Nathan D. Perlman Place, New York 3, New York.

Wanted immediately—registered occupational therapist for out-patient center, single fund agency. Beginning salary $425 per month. Children and adults treated. Five-day week, good fringe benefits. Staff also includes medical director, social worker, speech clinician and physical therapist. Write Pueblo Treatment Center, Inc., 1001 West St., Pueblo, Colo.

New OT building—openings for junior and senior occupational therapists in large progressive state mental hospital located twenty miles west of Spokane, in the heart of the Inland Empire. Unlimited facilities available for imaginative and energetic person to participate in forming and planning of occupational therapy program to be inaugurated in the new $750,0000 building. Paid vacations and holidays, sick leave, annual leave, retirement plan, and annual salary increase. Apply Personnel Office, Eastern State Hospital, Medical Lake, Washington.

Occupational therapist: vacancies exist in our physical medicine & rehabilitation service for 2 staff occupational therapists, GS-7, with salary range from $5355 to $6345. Facilities are modern with excellent opportunities for professional growth and advancement. Write or call Personnel Officer, VA Center, Dublin, Ga., for more detailed information.

Registered occupational therapist—for the Cerebral Palsy Center of Atlanta, Inc. Day school program, clinic and out patient services for 150 children ranging in age from 18 months to 18 years. Five day work week, public school holidays, 2 weeks summer vacation, and sick leave. Salary open. Send qualifications to Mrs. Harold M. Seymour, Administrator Cerebral Palsy Center of Atlanta, Inc., 1815 Ponce de Leon Avenue, N.E., Atlanta 7, Georgia.

WANTED IMMEDIATELY: Qualified occupational therapist for a staff position in the Rehabilitation Center for the Crippled, Huntsville, Alabama. The department is well equipped and a growing center in a rapidly expanding city. The salary range is from $4500 to $6000 annually, and other benefits. If interested please contact Mr. L. O. Dees, Administrator, Rehabilitation Center for the Crippled, 316 Longwood Drive, Huntsville, Ala.

DIRECTOR—modern hospital treating tuberculosis and allied pulmonary diseases. Occupational therapy and nurse affiliation programs. Patient rehabilitation conferences with heads of professional services. Complete cooperation of the medical staff. Close liaison with active state rehabilitation program. Five-day, 40-hour week, paid vacation, seven holidays, sick leave, social security. Excellent opportunity for progressive middle aged administrator.

Send resume to W. C. Anderson, Executive Director, Emily P. Bissell Hospital, 3000 Newport Gap Pike, Wilmington 8, Delaware.

Hospital-school (residential): Staff position open for OTR in active, integrated program, functionally geared incorporating physical, social, emotional aspects of treatment. For information write Virginia Reeves, O.T.R., Supervising Therapist, Illinois Children's Hospital-School, 2551 N. Clark St., Chicago 14, Ill.

A progressive approach to occupational therapy as a psychiatric treatment, opportunity for education and professional growth. Openings for 2 occupational therapists, registered or eligible for registration, for staff positions in 61 bed psychiatric dept. of general hospital. Limited out-patient program. Pleasant surroundings, good working conditions. Write Personnel Department, Pres.-St. Luke's Hospital, 1753 W. Congress, Chicago 12, Illinois.

Progressive 1600 bed state hospital has three openings for either trained or registry eligible occupational therapists. Beginning salary $395 a month. Administration is occupational therapy orientated and chances and opportunities for professional growth are unlimited. Hospital is located on large lake and offers many cultural and recreational facilities. Fringe benefits include one free meal, free uniform laundry, liberal retirement and medical benefits program. Write to: Kenneth Overly, O.T.R., Director of Occupational Therapy, Kentucky State Hospital, Danville, Kentucky.

OCCUPATIONAL THERAPIST for newly created department in psychiatric division of progressive teaching hospital. Modern facilities available within 28 bed psychiatric unit. Inquire: Mount Sinai Hospital, Director of Personnel, 2750 W. 15 Place, Chicago 8, Illinois.

OCCUPATIONAL THERAPIST, REGISTERED, for modern 221 bed hospital in rural area. U. S. citizen. Salary range $392.00/$491.00. With experience, starting salary second step ($415.00), outstanding qualifications at third step ($439.00). Retirement system, including social security. Write to Tulare-Kings Counties Hospital, Springville, California.

OCCUPATIONAL THERAPIST

College graduate—registered or eligible for registration. 5,000 bed AMA accredited state mental hospital in beautiful northern N. J. within an easy hour of NYC. Well OT oriented, progressive administration. Salary range $4,750-$6,178 for staff OT; $5,237-$6,809 for Sr. Fine civil service system with liberal paid vacations, holidays and sick leave benefits. Social security and state pension with free life insurance, also free Blue Cross expected Oct. 1. Low cost maintenance available. Write Richard E. Winans, Personnel Director, New Jersey State Hospital, Greystone Park, N. J. (near Morristown).

OCCUPATIONAL THERAPIST—immediate opening for work with multiple handicapped children. Program includes all therapies and services. For details, contact Director, West River Hospital-School, Hot Springs, South Dakota.

Staff position for registered occupational therapist in community rehabilitation center offering comprehensive services. Opportunity for working with a wide variety of physical disabilities in all age groups. Salary commensurate with experience. Write Robert A. Silvanik, Administrator, Rehabilitation Center of Summit County, 326 Locust Street, Akron 2, Ohio.

Staff position available in 600 bed teaching hospital. Located in scenic surrounding and within easy driving distance of coast and metropolitan areas. Liberal personnel policies. Contact: Personnel Office, University of Virginia, 1416 W. Main St., Charlottsville, Va.

STAFF OCCUPATIONAL THERAPIST: Position available. Salary range $4,325-$4,975 depending on experience. Merit increases. 37½ hr. week, vacations, holidays, sick leave. Well equipped dept. including prevocational evaluation, affiliated with Northwestern Medical School. OT student training program. Comprehensive rehabilitation program for physically disabled in and out-patients. 70 bed hospital. Congenial atmosphere, excellent opportunity for personal development. Should be graduate of approved school of OT and hold membership in AOTA or Registry. Contact Mr. Clark Sabine, O.T.R., Rehabilitation Institute of Chicago, 401 E. Ohio St., Chicago 11, Ill.

The Nebraska Psychiatric Institute is accepting applications for staff therapists working in progressive occupational therapy department. Excellent opportunity to gain experience working closely with graduate program offering masters in psychiatric occupational therapy.

Contact Mr. H. Dwyer Dundon, O.T.R., Chief Occupational Therapy, Nebraska Psychiatric Institute, 602 South 44th Avenue, Omaha 5, Nebraska.

OCCUPATIONAL THERAPIST—For a rehabilitation center connected with a 275-bed general hospital. In and out patient services. Excellent opportunty. Salary depending on experience and qualifications. Liberal benefits. Contact: Coordinator, Mercy Hospital Rehabilitation Center, Oshkosh, Wisconsin.

OCCUPATIONAL THERAPIST needed to head department in 337 bed medical center. Work in both pediatrics and psychiatry. New and expanded rehabilitation program. Rewarding experience. Apply Personnel, Menorah Medical Center, 4949 Rockhill Road, Kansas City, Missouri.

MARYLAND—Senior therapist position now available at small, modern hospital situated in pleasant residential suburb of Baltimore. Requires AMA approved course in OT and two years OT experience in a hospital, clinic or public health program. Salary: $5040-6302 (maximum in six years).

Write: Commissioner of Personnel, 301 West Preston Street, Baltimore 1, Maryland. Applications for "Senior Occupational Therapist" must be filed as soon as possible.

Registered occupational therapist, experienced or inexperienced. Salary $4500 to $5400. Good personnel policies, 37½ hour work week. Crossroads is in a new modern air conditioned building on a beautiful wooded area. It is a comprehensive center. Indianapolis is a thriving, rapidly growing city with many recreational, educational and cultural opportunities.

Write Dr. Roy E. Patton, Crossroads Rehabilitation Center, Indianapolis 5, Indiana.

Occupational therapist for full time position in accredited small, open private psychiatric hospital. Salary based on experience; beautiful surroundings. Elizabeth Anderson, Silver Hill Foundation, New Canaan, Connecticut.

Position available for registered occupational therapist in 950 bed general hospital area. Beginning salary dependent upon experience. Contact Kathryn J. Kelly, Director, Occupational Therapy Department, University of Iowa Hospitals, Iowa City, Iowa.

WANTED: An experienced O.T.R. to head an expanding therapy program in a hospital of 970 mentally ill patients. Salary $400 to $600 per month, depending on training and experience. Write Personnel Officer, Mental Health Institute, Mt. Pleasant, Iowa.

OCCUPATIONAL THERAPIST for duties in State Crippled Children's Service, merit system, retirement benefits, liberal vacation and sick leave. Salary: Occupational Therapist I without experience, $4,680; Occupational Therapist II with experience, $5,220-$5,940. Write to Director, Crippled Children's Service, State Board of Health, Dover, Delaware.

Position open for registered occupational therapist in physical disabilities and/or G.M.&S. in excellent educational setting with student training program. Starting salary $345, paid vacation (2 weeks), holidays, sick leave. Laundry and faculty privileges. Write Miss Nancy Moulin, O.T.R., Supervisor, Occupational Therapy, Room 287, Ohio State University Hospital, 410 W. 10th Avenue, Columbus 10, Ohio.

OCCUPATIONAL THERAPY CONSULTANT. New opening for second OT to assist in developing a statewide rehabilitation education service. Challenging opportunity to work with professional and lay groups in nursing homes, public health agencies and hospitals. Expanding program includes patient consultation, teaching in rehabilitation in-service programs, and assisting long-term care institutions in development of activity programs. Work with other staff consultants in physical therapy, nursing and speech and hearing. Live in Madison with travel to other parts of the state. O.T.R. and four years of relevant professional experience. Salary range: $6,912-$8,952. R. J. Siesen, Personnel Officer, State Board of Health, Madison 2, Wisconsin.

Immediate openings for occupational therapists in 2500 bed AMA accredited psychiatric hospital. Positions available include senior OT. Salary range $5237-6809 and staff OT $4750-6178. Must be college graduate and registered or eligible for registration. Well OT oriented administration, OT clinical training program projected. Forty-hour week, paid vacation, holidays, sick leave, medical-surgical and major medical plan; social security and retirement plan available. Low cost housing may be available. Contact Personnel Director, Ancora State Hospital, Hammonton, New Jersey.

Openings for two staff O.T.R.'s. State school for retarded near Boston. Diversified program including prevocational evaluation, sub-contract workshop, and emotional problems. Salary range $4120-5213. Contact Mrs. Joress, Fernald State School, Box C, Waverley, Mass.

Position open for graduate OT in state chronic disease and rehabilitation hospital. Salary range from $158.63 to $221.46 biweekly, $180 per year increment, full medical and health insurance provided by state, $316 full maintenance per year, 11 paid holidays, sick leave, three weeks paid vacation, state retirement plan and social security, five day-40 hour week. Department treats variety of disabilities under direction of physiatrist. Apply to Dr. George C. Wilson, Superintendent and Medical Director, Uncas-On-Thames, Norwich, Conn.

Occupational therapist, department head, home for aged; also opportunity to develop program for new progressive retirement village adjoining. Salary commensurate with training and experience. Accommodations if desired. The Presbyterian Home, 3200 Grant Street, Evanston, Illinois.

Occupational therapist, state mental hospital. New recreational building now under construction. Large adolescent program. Graduates of approved school of occupational therapy, $335.00 to $425.00 per month. Registered occupational therapist with two years of experience, $400.00 to $425.00 per month. Registered occupational therapist and four years of experience, two of which have been in a supervisory role, $475.00 to $575.00 per month. Above starting salary may be paid for experience beyond the minimum. Apply Ralph B. Cary, Personnel Officer, Logansport State Hospital, Logansport, Indiana.

O.T.R.'s: If interested in
FIELD: Rehabilitation
LOCATION: Maryland
SALARY: Head OT: $5350.00-$6688.00
Senior OT: $5040.00-$6302.00
OT: $4540.00-$5677.00
CONTACT: Dr. F. I. Mahoney or Mrs. Jean Dana, O.T.R.
Montebello State Hospital
2201 Argonne Drive
Baltimore 18, Maryland

Staff OT requiring registration or registration eligibility; supervision is available; salary range $4800-$5000 (depending on experience and qualifications); transportation available; 40-hour work week; sound pension plan; two-weeks vacation and sick allowance per year; liberal holidays; one-meal per day; 2500 bed hospital (mainly geriatrics). There are opportunities for advancement. Oak Forest Hospital, Oak Forest, Illinois.

WANTED OCCUPATIONAL THERAPIST, $5,280 to $6,192. Seeking a stimulating environment for professional growth, exper. and educational opportunity. Medically supervised occupational therapy programs in neurological, orthopedic, pediatric, chest medical, geriatric and psychiatric areas. Location is ideal for cultural and educational interests. Civil Service benefits. Apply to Mrs. Lucyann R. Martin, O.T.R., Head Occupational Therapy, Box 361, Los Angeles County General Hosp., 1200 N. State Street, Los Angeles 33, California.

Immediate opening for registered occupational therapist to organize and develop a pre-vocational evaluation service in connection with the department of physical medicine and rehabilitation at the Marion County General Hospital. New, well-equipped pre-vocational section adjacent to the occupational therapy department. If needed, will provide special training for qualified applicant.

For further information write Dr. Felix Millan, Assistant Director, Department of Physical Medicine and Rehabilitation, Marion County General Hospital, 960 Locke Street, Indianapolis 7, Indiana.

A variety of experiences are available for eleven more staff therapists in a chronic disease (all ages) and geriatric program in a 2000 bed city hospital and home affiliated with New York Medical College. Positions are available in adult rehabilitation, children's rehabilitation, psychiatric-geriatrics ward program (100 bed), general ward program, home care, pre-vocational, adaptive equipment and woodworking (male therapist preferred), and special studies. We have eight O.T.R.'s and a student training program. Seven hour day, five day week, four weeks paid vacation, eleven holidays, twelve days sick benefit, six hour day for summer months. Salary open.

Write to Mrs. Carolyn Aggarwal, O.T.R., Chief, Bird S. Coler Hospital and Home, Welfare Island, New York 17, New York.

Near the southern Maine coast, two hours from Boston, there are two openings for O.T.R.'s in a newly constructed dynamic treatment center for the emotionally disturbed and mentally retarded. Salary range: $4,680 to $6,552 depending on qualifications. Liberal personnel policies and excellent retirement system. Contact: Peter W. Bowman, M.D. Supt., Pineland Hospital & Training Center, Box C, Pownal, Maine.

Wanted: Occupational therapist for 147 bed chronic disease hospital, with active rehabilitation program. Excellent salary and benefits. Living accommodations available at hospital. Apply: Harold M. Owen, Administrator, American Legion Hospital, Battle Creek, Michigan.

O.T.R. OPENING JANUARY 1, 1962. Progressive school and treatment center for physically handicapped children. R. B. Rembolt, M.D., Medical Director. Salary $4500-$5200, increments to $6500. Vacations same as public schools. (Christmas, etc.) plus three weeks in August. Write Exec. Dir., UCP Center, 1201 8th St. N.W., Cedar Rapids, Iowa.

OCCUPATIONAL THERAPISTS for large Federal mental hospital in nation's capital. Opportunities for self-determination in the selection and development of treatment programs for patients of all ages and for self-development in a progressive educational program. Yearly salaries start at $4345 and $5355. Liberal fringe benefits such as vacation and sick leave, Civil Service retirement coverage, and employer contributions toward employee health benefits and life insurance programs. For more information call or write, Personnel Office, Saint Elizabeths Hospital, Washington 20, D. C.

OT CONSULTANT. Serve as member of consultant team; assist small psychiatric hospitals in development of active treatment programs. Need O.T.R. and at least three years experience in psychiatry. Involves travel. Salary range $5712-$7212. Contact Patricia Thornton, O.T.R. Division of Mental Hygiene, State Office Building, Madison, Wisconsin.

O.T.R. FOR TREATMENT OF RETARDED CHILDREN. Excellent opportunities in disability field in which OT is becoming more active. Salary with experience $5,412-$6,792; without experience, $4,812-$6,072. Southern Colony and Training School, Union Grove, near Racine. Write Personnel Office, or Patricia Thornton, O.T.R., Division of Mental Hygiene, Madison, Wisconsin.

STAFF OCCUPATIONAL THERAPIST. A full-time position offering the diversification of half-time in a small department in a growing out-patient rehabilitation center and half-time assisting to initiate occupational therapy program in an in-patient facility. Prevocational and functional occupational therapy with all types of disabilities, physical and psychiatric. Under immediate supervision of chief of department. Assist in coordination with medical, vocational and social services. Starting salary: $4,200-$5,000, depending on experience. Apply: Sidney S. Robbins, Executive Director, Rochester Rehabilitation Center, Inc., 50 Prince Street, Rochester 7, New York.

Vacancy at cerebral palsy school operated by Sunnyview in one of local schools. Duties are on year round schedule and include experience each year in Sunnyview. See other ad above. Apply Administrator, Sunnyview Rehabilitation Center, Schenectady 8, New York.

Position for staff occupational therapist available immediately in a university affiliated rehabilitation center. Program includes functional therapy, ADL and diversional activities. Twelve days vacation and sick leave annually. Salary open and dependent on experience. Contact Marion F. Labushohr, chief occupational therapist, Occupational Therapy Section, Nebraska, University-Douglas County Rehabilitation Center, Douglas County Hospital, 4102 Woolworth Avenue, Omaha 5, Nebraska.

Imaginative, enthusiastic, attractive, hard-working O.T.R. needed for a difficult new position. Pay starts at $400 per month. You also get retirement, sick leave and paid vacation; plus the opportunity to live in Oregon. Write or wire Mr. Robert Miller, O.T.R., Oregon State Hospital, Salem, Oregon, for an application.

Available position for registered Jr. occupational therapist, little experience needed. To assist supervisor of occupational therapy program for T.B. patients, in Sunnyside Sanatorium.

For further information write Dr. Felix Millan, Assistant Director of Department of Physical Medicine and Rehabilitation, Health and Hospital Corporation of Marion County, 960 Locke Street, Indianapolis 7, Indiana.

CHIEF OCCUPATIONAL THERAPIST to supervise a small department in a growing out-patient rehabilitation center, serving all types of disabilities, physical and psychiatric. Involves prevocational and functional occupational therapy. Coordinate with medical, vocational and social service departments. Adequate assistance available. Position available January 1, 1962. Salary: $4,675-$6,265, depending on experience. Apply: Sidney S. Robbins, Executive Director, Rochester Rehabilitation Center, Inc., 50 Prince Street, Rochester 7, New York.

Occupational therapy opening in 270 bed general medical and surgical hospital. Grade GS-7 with beginning salary of $5,355. For further information write: Personnel Officer, Veterans Administration Center, Sioux Falls, South Dakota.

Applications continually accepted for staff therapists in REHABILITATION CENTER treating children and adults. OT department now in new section of building, equipped with many new items. Current staff of six is being gradually increased to meet greater in and outpatient capacity. Opportunity for program development and teaching. Close working relations with doctors, other staff and parents. Number of children allows for individual treatment. Progressive personnel policies. Salary commensurate with training and experience. Location ideal for cultural interests and all sports. Further information and attractive brochure furnished on request. Apply to Administrator, Sunnyview Rehabilitation Center, Schenectady, New York.

Immediate opening for occupational therapist in 100 bed tuberculosis hospital, with medical and nursing teaching programs, in the West Side Medical Center of Chicago. Start at $5,100 or $5,940. Write: Dr. Karl H. Pfuetze, Medical Director and Superintendent, Chicago State Tuberculosis Sanitarium, 1919 West Taylor Street, Chicago 12, Illinois.

O.T.R. FOR NEW CHILD AND ADOLESCENT TREATMENT SERVICE. Under direction of child psychiatrist, help develop the program. Closely integrated service. Need year of experience, preferably with emotionally disturbed children. Range $5,412-$6,792.

O.T.R. FOR INTENSIVE TREATMENT SERVICE FOR ADULTS. Staff of 9 OT's. Well coordinated service. Salary: with experience, $5,412-$6,792; without experience, $4,812-$6,072.

Winebago State Hospital, Winnebago, on the lake, near Oshkosh. Write the Personnel Office, or to Patricia Thornton, O.T.R., Division of Mental Hygiene, State Office Building, Madison, Wisconsin.

Registered occupational therapist for well-equipped private rehabilitation facility in New York City, directed by a qualified physiatrist, concentrating on the rehabilitation of industrial accident cases, with stress placed on a program of functional therapy. Staff therapist to do individual functional therapy and pre-vocational evaluations. Work under direct supervision of a physiatrist and with a full team of physiotherapists.

Salary commensurate with qualifications and experience.
Contact: Frederick Ziman, M.D.
145 West 86th Street
New York 24, New York.

OCCUPATIONAL THERAPISTS FOR STATE OF HAWAII. One therapist (male preferred) to work with mentally ill male patients and another therapist for recreation services and activities of rehabilitation and therapy program for Hansen's Disease patients. Requires graduation from OT school approved by Council on Medical Education & Hospitals and which included or is supplemented by 1 year supervised OT work experience. Salary range: $5076-$6156. Contact Dept. of Personnel Services, 825 Mililani St., Honolulu 13, Hawaii.

Public health occupational therapist: At least one year's experience including work with children, to work with crippled children section program of the State Department of Health. Travel to clinics, centers and homes is required. New liberal personnel policies. Merit system coverage. Apply: Connecticut State Department of Health, 165 Capitol Avenue, Hartford, Connecticut.

Occupational therapist: For pre-vocational unit—in a well integrated out-patient Easter Seal Rehabilitation Center. Patient load (work adjustment program) consists of individuals with physical disabilities, mental and emotional illness, and mental retardation.

Program is well established. Continued growth and development will be dependent on individual initiative under department supervisor's guidance. Continuity of program is enhanced by home care, homebound employment services, physical restoration and activities of daily living units, sheltered shops, hospital industries, and other on-the-job facilities.

Salary based on educational qualifications and experience in accordance with regional personnel practices.

Apply: Miss Clari Bare, O.T.R., Hartford Rehabilitation Center, Inc., 2 Holcomb Street, Hartford, Connecticut.

Opening immediately for registered occupational therapist interested in psychiatry. Diagnostic and acute treatment service with a bed capacity of about 70 patients, small occupational therapy unit within the department. Therapist should have ability to independently plan and carry out occupational therapy program under the direction of the physicians.

For further information write Dr. Felix Millan, Assistant Director of Department of Physical Medicine and Rehabilitation, Health and Hospital Corp. of Marion County, 960 Locke Street, Indianapolis 7, Indiana.

Immediate opening for therapist interested in initiating occupational therapy in an outpatient crippled children's clinic located on the border of Mexico and near lovely beach. One month vacation in summer and one week at Christmas. Salary open. Contact: George Odabashian, Pres. Brownsville Society for Crippled Children, Inc., Box 841, Brownsville, Texas.

Occupational therapist registered. Geriatrics and medical services. Start $4710. Annual merit increases to $5290. Liberal personnel policies. Apply Personnel, Grasslands Hospital, Valhalla, N. Y. LYric 2-8500 Ext. 61.

Opening for occupational therapist—full time—accredited private psychiatric hospital—70 bed. Located in Westport, Connecticut. (One hour from New York by train or car.) Write or call Hall-Brooke Hospital, Box 31, Greens Farms, Westport, Conn.

Staff therapist positions available in both Physical Disability Clinic and Psychiatric Clinic of a university hospital.

Write: Mrs. Mary K. Bailey
Chief Occupational Therapist
The Johns Hopkins Hospital
Baltimore 5, Maryland

Staff therapist for expanding rehabilitation hospital. Comprehensive physical disability program. PM&R service under the direction of physiatrist. Excellent benefits and working conditions. Salary commensurate with experience. Provisions for periodic salary increments.

Write Chief Occupational Therapist, Rest Haven Rehabilitation Hospital, 1401 South California Blvd., Chicago 8, Illinois.

We need two staff therapists for our expanding department in dynamic and social psychiatry. Position offers excellent opportunities for learning and teaching because of our medical school affiliation. Liberal benefits, salary open. Write: Nancy Stone, O.T.R., coordinator of activities, Bronx Municipal Hospital Center, Bronx 61, New York.

OCCUPATIONAL THERAPISTS wanted for the state of Hawaii. One therapist (male preferred) to work with mentally ill male patients and another therapist for recreation services and activities of rehabilitation and therapy program for Hansen's Disease patients. Must be graduates of OT school approved by Council on Medical Education & Hospitals and which included or is supplemented by 1 year supervised OT work experience. Salary range: $5076-$6156. Contact Dept. of Personnel Services, 825 Mililani St., Honolulu 13, Hawaii.

Challenging position open for staff therapist in rapidly expanding OT department in progressive general hospital. Emphasis on team approach in psychiatry, geriatrics, and physical disabilities. New outpatient rehabilitation clinic. Contact: Mrs. Caroline M. Bourestom, Director of Occupational Therapy, Allen Memorial Hospital, Waterloo, Iowa.

OT for rehabilitation center. Presents challenge of multi-purpose program. Forty hour, five day week. Three weeks vacation. Salary open based on experience. Write Dir. Curative Workshop, 342 S. Webster Ave., Green Bay, Wis.

REGISTERED OCCUPATIONAL THERAPIST permanent full-time work; 31 psychiatric bed unit in a 500-bed general hospital. Contact: Personnel Office, Toledo Hospital, 2142 No. Cove Blvd., Toledo, Ohio.

Opening for experienced, registered occupational therapist in expanding cerebral palsy treatment center. Children and adults; five day week; paid vacation and sick leave; social security. Apply: William S. Guitteau, Executive Director, United Cerebral Palsy of Broward County, 100 S.E. River Drive, Ft. Lauderdale, Florida.

WANTED: occupational therapist for a 75 bed psychiatric unit of a large general hospital situated on the campus of Western Reserve University. Experience desirable but will consider recent graduate. This is an intensive treatment and diagnostic center with psychoanalytic concepts; program is well established and integrated with other treatment services; facilities and personnel policies are excellent wtih many opportunities for personal growth and development. Salary commensurate with experience. Apply: Charlotte Burpee, Chief, Psychiatric Occupational Therapy, University Hospitals of Cleveland, 2040 Abington Road, Cleveland 6, Ohio.

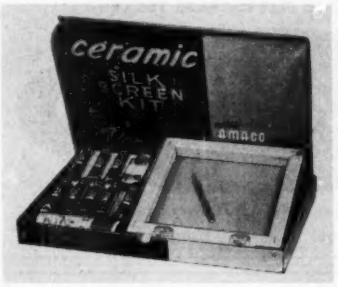
Have You Tried?

The "Trading Post Section" of the *American Journal of Nursing*, October, 1961, suggests that foam rubber curlers be slipped over small objects to help patients having difficulty in grasping and holding small articles.

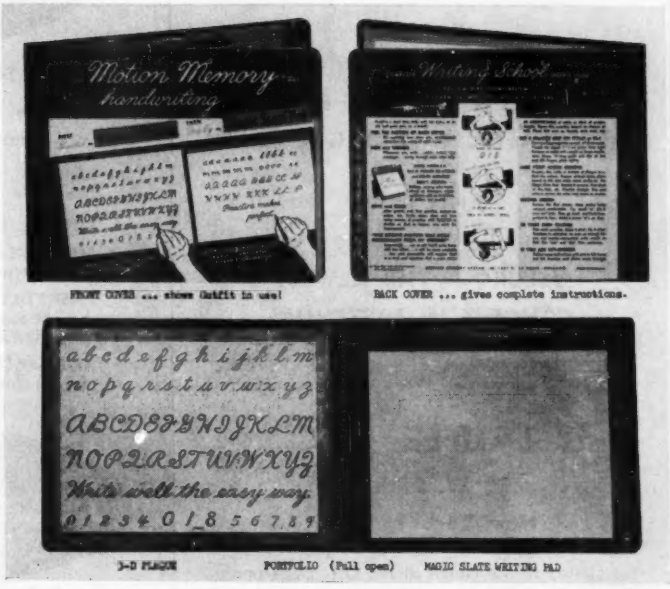
* * *

The latest letter from REHABILITATION PRODUCTS, Evanston, Illinois, enclosed descriptive material of the Lakeland Automatic Page Turner and an easily adjustable walk-off tilt table. Send for the brochures.

In addition, Rehabilitation Products disclosed they are now offering counseling services for enlarging, remodeling or building new units.



Silk screening is a challenging art process and a practical one for duplicating original designs on glazed ceramic or fired metal enamel pieces such as plates, tiles and plaques. An Amaco Ceramic Silk Screen Kit saves lots of time since all the necessary materials have been assembled in one convenient package. It contains a hinged wood frame with inside measurements of eight inch by eight inch, stencil film, knife, 8 tubes of ready-to-use Versa Colors, two glazed tiles and other required supplies. Decorated ceramic pieces are fired to Cone 018 (1328° F.); mental enameled pieces for one and one-half minutes at 1450° F.



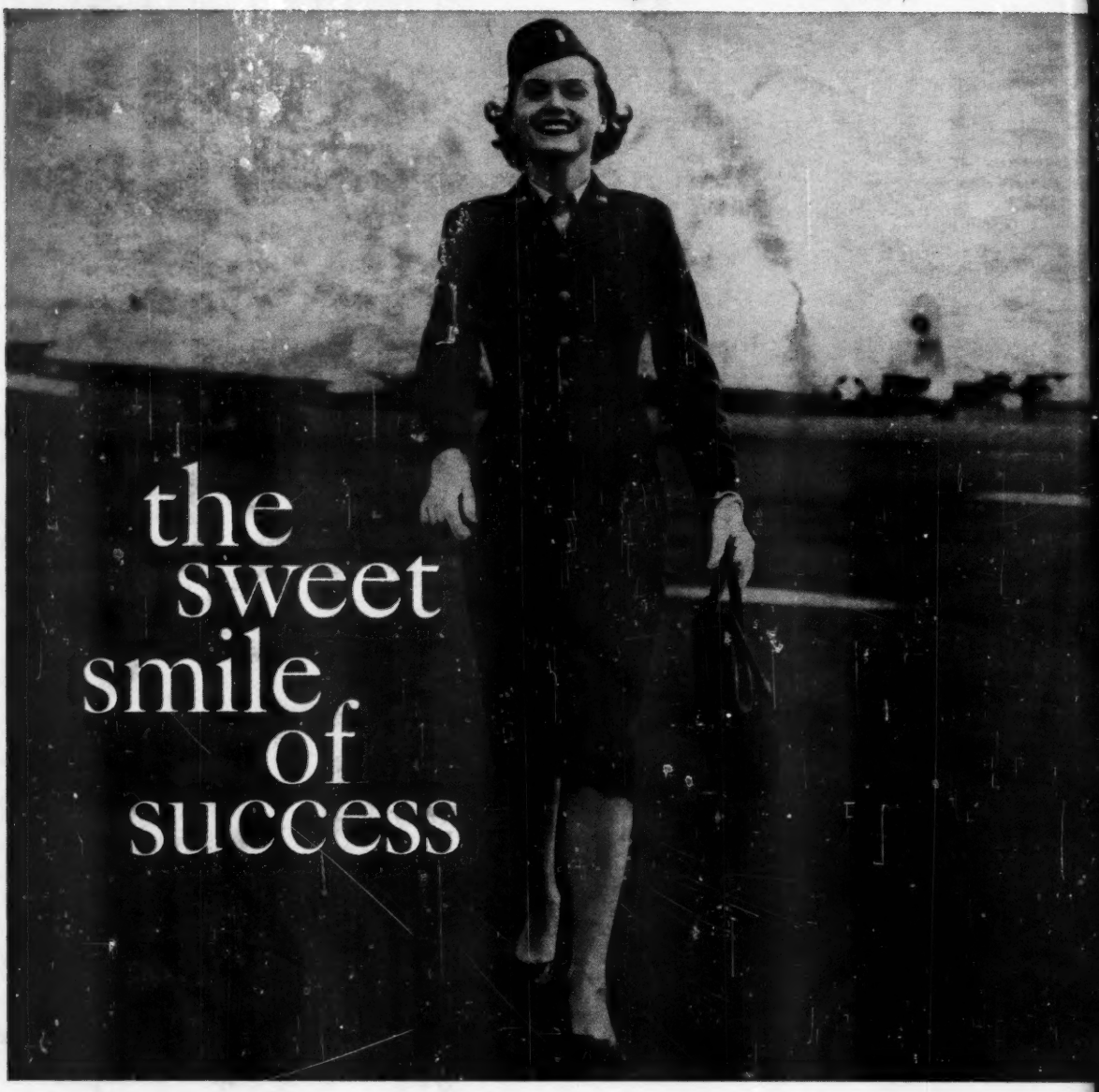
FRONT COVER ... shows Outfit in use! BACK COVER ... gives complete instructions.

3-D PLAQUE PORTFOLIO (Full open) MAGIC SLATE WRITING PAD

Grownups and children with poor handwriting habits can learn relaxed legible writing on grooved practice plaque with authentic, flow-script alphabet, capitals and numerals in amazing new Motion Memory Handwriting Outfit.

Practice is simple. Just use the special stylus provided in the kit, or a pen or pencil. Slide the point along the grooved letters of the practice plaque to get guided-motion practice, then write the same memory-guided letters on the magic slate pad alongside. It is easily erased again and again by lifting films. No complicated eye-hand coordination is needed, muscle-sense quickly learns right habits.

Motion Memory Handwriting Outfit, in durable eight and one-half by eleven inch four color portfolio, contains the seven inch by 10 inch practice plaque, seven inch by nine inch magic slate pad, 5 inch stylus and full directions for beneficial use. It's a complete writing outfit. It costs $1 plus 25c for handling. Order from MOTION MEMORY, 221 N. LaSalle Street, Chicago 1, Illinois.



If you are a graduate Occupational Therapist, you may be eligible for an Officer's Commission in the U. S. Air Force Medical Specialist Corps. You can build a career marked by good pay, steady advancement and solid security. In your trim Air Force uniform you will be admired and respected wherever you go...as a key specialist of the Aerospace Team.

Air Force leaders know that proper therapy can help restore good health and performance among those in our country's number one line of defense. If you are interested in a rewarding career of professional service as an Air Force Occupational Therapist, clip and mail this coupon.

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